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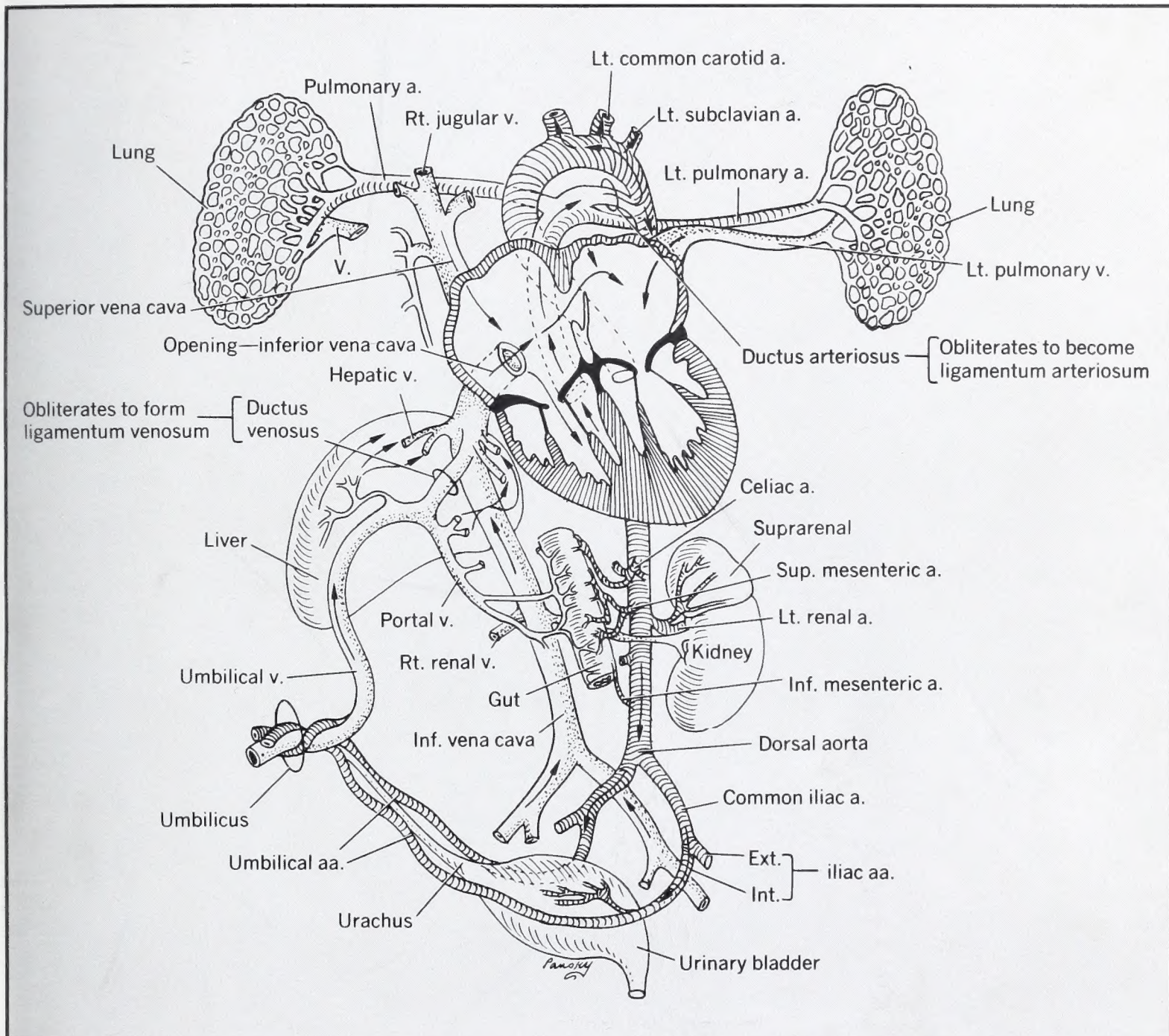
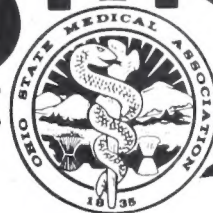
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JANUARY 1976
Volume 72, Number 1

THE OHIO Medical Journal

STATE



PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

EXPERIENCE IN MANAGEMENT OF
HYALINE MEMBRANE DISEASE, PAGE 23

MEDICAL ILLUSTRATING HOBBY OF
COLLEGE OF OHIO PHYSICIAN, PAGE 7

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- Predominant psychoneurotic anxiety

- Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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1. For the relief of symptoms associated with cerebral vascular insufficiency.
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3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

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JANUARY, 1976

NO. 1



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COVER: The illustration on the cover is an original drawing by Ben Pansky, M.D., Ph.D. This medical illustration appears in Dr. Pansky's text *Dynamic Anatomy and Physiology* published by Macmillan Publishing Co., Inc. The drawing is reproduced courtesy of Dr. Pansky.

Physicians on Rolls of Ohio Unclaimed Funds Section

The Unclaimed Funds Section of Ohio's Department of Commerce is looking for owners of \$19 million. This money has come into the hands of the department in a variety of ways: savings deposits unclaimed for ten years, security deposits and overpayments to public utilities unclaimed for five years, insurance payments unclaimed for ten years, and the like.

Physicians and hospitals in Ohio are listed on the department's records. They may have money coming from uncashed payment for service checks, collection agency receipts, insurance payments or utility deposits. Hospitals are often the recipients of insurance checks.

As of August 1975, there were 210,000 names on the records. Any physician or hospital desirous of knowing whether his name is listed should write the Director of Commerce, Unclaimed Funds Section, 180 East Broad Street, Columbus, Ohio 43215. Include in the letter name and present address. The division will check its records to see if the writer is listed among owners of funds. If the name appears, a claim form will be mailed to the writer. He should complete and return the form including proof of who he is and that he lived or worked at the address listed on the division's records.

Money will be sent bona fide claimants within five weeks of receipt of the claim form. Refunds will include 5 percent simple interest.

Limited Open Enrollment for OSMA Excess Major Med. Plan

Until February 29, 1976, The Life Insurance Company of North America is offering an open enrollment period for OSMA's new \$250,000 Excess Major Medical Plan. This plan offers a \$10,000 or \$20,000 deductible. OSMA members who are under age 70 and who apply prior to February 29 are guaranteed that coverage will be issued. After February 29, 1976, only members under age 60 may apply.

During the past 12 years, the OSMA Major Medical Plan has undergone only three rate increases. One of these increases became effective December 1, 1975. At that time, a coordination of benefits provision was added. Had it not been added, the necessary rate increase would possibly have been 20 percent higher.

The coordination of benefits provision provides that the insured's deductible is either the \$300, \$500, or \$1,000 deductible plan he has, or the amount of benefits paid under any other group or group-type contract. Coordination of benefits does not apply where the insured holds an individual policy of some kind.

OSMA members may participate in a number of sponsored Health Insurance Plans, such as:

(A). **OSMA Major Medical Plan** offering (1) a three-year benefit period with up to \$20,000 payable on any one illness or injury involving the member or an insured family member; (2) optional coverage for professional services; (3) a choice of deductibles; and (4) once insured, continuous coverage regardless of age.

(B). **OSMA Hospital Indemnity Plan** offering (1) various daily benefit levels up to \$90 per day; (2) guaranteed acceptance to all members under age 70 who apply during the brief open enrollment period now available; (3) federal income tax-free benefits paid to the member; (4) continuous coverage regardless of age with benefits and rates reducing at age 65.

(C) **OSMA \$250,000 Excess Major Medical Plan** featuring (1) member's choice of \$10,000 or \$20,000 deductible which fits over the basic OSMA Major Medical Plan; (2) a five-year benefit period commencing after deductible is reached; (3) payment of 100 percent of all eligible expenses, including professional services, after expenses reach \$20,000 or after benefits taken care of by other medical insurance the member has are exhausted, whichever is larger; (4) guaranteed issue until February 29, 1976, to all OSMA members under age 70 years.

whether the protection he already has is sufficient or whether he should add one or more of these plans. The open enrollment period for the \$250,000 Excess Major Medical Plan ends February 29, 1976.

Any member having any questions concerning these plans should call collect Spencer Cunningham, administrator of these programs, Daniels-Head and Associates, Inc., Portsmouth, Ohio, (614) 354-4561.

OSMA Concurs With AMA Stand On Advertising by Physicians

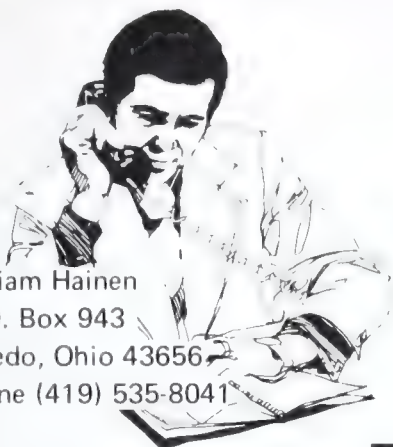
The following official statement was released by OSMA to the Ohio media December 23, 1975:

"OSMA concurs with the statement made by the AMA in response to the recent complaint of the Federal Trade Commission.

"The complaint is directed at the AMA's Code of Ethics, more than 100 years old. It is ironic that the FTC should attack a code devised and operated as a standard of conduct in the best interests of the patient.

"Advertising by a professional is the very antithesis of professionalism. Physicians should not solicit patients. A patient should go to a doctor on the basis of need not on the basis of advertising. Do patients want to be treated in accordance with the best professional judgment concerning their health and safety? Or do they want medical services that are sold and promoted?" "

(NEWS continued on page 8)



William Hainen
P. O. Box 943
Toledo, Ohio 43656
Phone (419) 535-8041

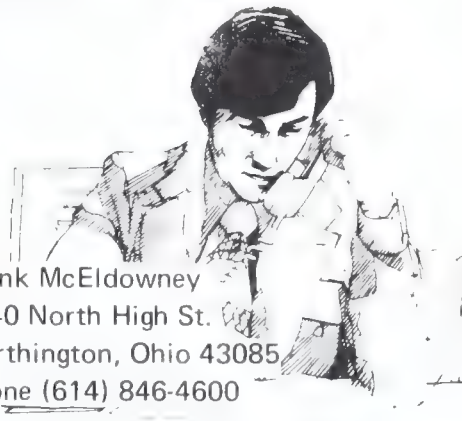


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He's A Handy Guy To Have Around

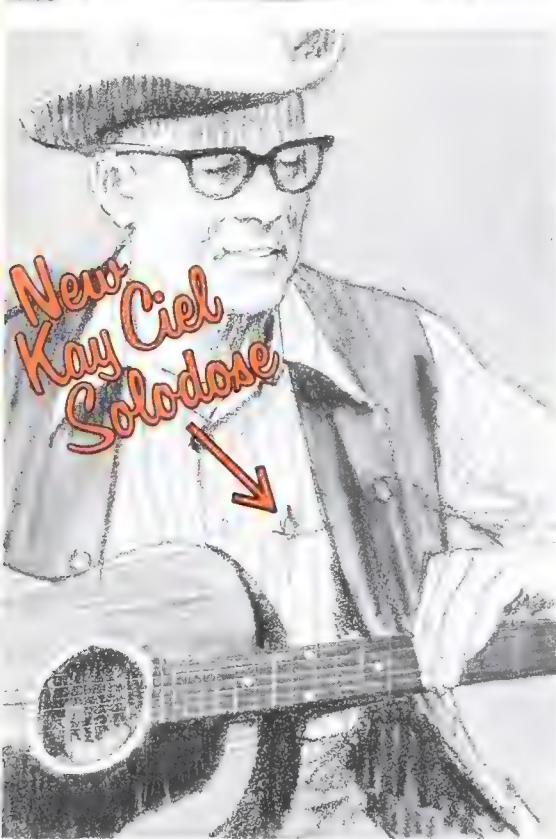
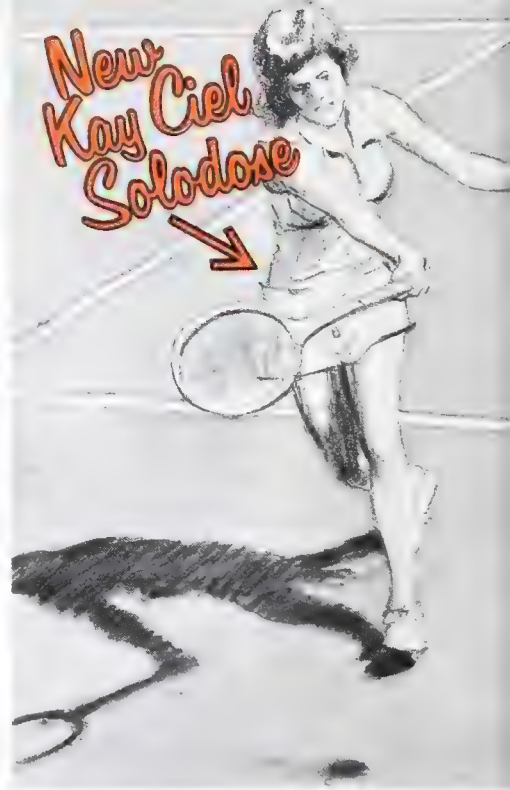
When you have a question, problem or concern about Blue Shield, we have a man who can help—your Ohio Medical Indemnity professional relations expert. Located right in your area, it's his job to short-cut . . . both physically and administratively . . . the distance between your office and our main office.

He's the man to call to get answers and action and save yourself time and trouble. He's nearby when you need help . . . and he'll go out of his way to see you get it.

If by some chance you haven't gotten acquainted with your Blue Shield professional relations man yet, give him a call today. You'll find he's a handy guy to have around.



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KAY CIEL[®]**
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chloride, 1.5g.)
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Medical Illustrating Hobby Of College of Ohio Physician

The Medical College of Ohio at Toledo boasts a unique faculty member who is also a medical illustrator. Ben Pansky, M.D., Ph.D., is Director of Medical and Dental Gross Anatomy as well as a self-taught medical illustrator with several publications to his credit.

Dr. Pansky received his undergraduate and graduate degrees in anatomy from the University of Wisconsin. He became assistant and then associate professor of anatomy at New York Medical College. In addition, he served as Director of the Basic Sciences of the School of Nursing.

Sixteen years after joining the faculty at New York Medical College, Dr. Pansky earned his medical degree from the college having entered the curriculum at age 37. Following graduation he served an internship and pathology residency at Presbyterian Hospital in New York.

In 1970, Dr. Pansky moved to Toledo as a full professor of anatomy at the Medical College of Ohio. In addition to his anatomical teaching duties, he carries on research in diabetes and immunology.

During his year at New York Medical College, Dr. Pansky published his first text, *Functional Approach to Neuroanatomy*. This text, developed from an anatomy meeting, was coauthored by Earl House and published by McGraw Hill. Dr. Pansky was responsible for the cover and all plates. The book sold well, and the first edition went through over nine printings. The second edition came out in 1967, and the third edition is under development. This text has also been published in both Japanese and Spanish.



Ben Pansky, M.D., Ph.D.



Dr. Pansky also completed *A Review of Gross Anatomy*, published by MacMillan-Collier, during his years in New York. As a medical student, he completed the second edition of this text. A third edition was published in 1975.

Dr. Pansky spent recent years working on *Dynamic Anatomy and Physiology*, published by MacMillan-Collier. This text is designed for use by nursing students and other undergraduates in allied health professions. The book approaches the subject by means of cellular orientation and then proceeds into systemic organization. Dr. Pansky is presently working on a slide series and a laboratory manual to accompany the text. *The Journal's* cover this month is a Pansky illustration from this text.

He has also illustrated *Anatomical Study Wheels*, MacMillan-Collier publisher. This study tool is composed of eight wheels on which all information found in Gray's *Anatomy* and *Review of Gross Anatomy* appear.

Dr. Pansky has been drawing since his teens when he served as cartoonist for his high school paper. He has not, however, had any formal training. Dr. Pansky does all his illustrating in his spare time. He stated, "When my hand is steady, I ink all I can." There are no halftones in *Review of Gross Anatomy* as all dimensions are shown through the use of lines. His color illustrations are done in colored pencil.

Dr. Pansky commented that he would love to sit back and draw for the love of drawing. He enjoys writing and illustrating his own works including children's books, none of which has been published. He would also like to sculpt. Future projects include a tape series to accompany *Dynamic Anatomy and Physiology* and a text on embryology from the illustrator's viewpoint.

Dr. Pansky's wife is a social service social worker with Family Services of Greater Toledo. The Pansky's have one son, a student at Oberlin College.

Need for Independent Data Collection Center Discussed at PSRO Symposium

Columbus was the site of a Health Data and Information Systems Relating to PSRO Programs Symposium held in November.

William Jesse, M.D., Special Assistant to the Bureau of Quality Assurance of the Department of Health, Education, and Welfare, noted that there were six basic problems in the PSRO program. These problems are (1) the number of patient admissions to review (this number will eventually reach 11 million); (2) the number of agencies and providers involved; (3) the need to coordinate national report needs with local data collection; (4) a variety of pressures from various data collecting agencies; (5) confidentiality and privacy of data; and (6) competing interests in the federal program.

Dr. Jesse also pointed out that data collection is limited financially to a maximum of 75 cents per discharge. Collecting agencies are chosen by bids.

George Leicht, M.D., President-Elect of the Cleve-

land Academy of Medicine, presented a physician's viewpoint. Dr. Leicht, who is also President of Region XII Physicians Peer Review Organization, stated that there is little room for local PSRO flexibility as the locals must react to federal bureaucratic guidelines.

Also, Dr. Leicht said providers are scapegoats for the cost factor. "The federal government says it wants quality care, but it really wants cost constraints," stated Dr. Leicht. "HB-603 could be a stepping-stone in provider-directed health care," he added.

Dr. Leicht spoke pointedly when he said, "For quality medical care and concepts of peer review, it might be best to let PSRO die because of its ultimate effect on medical care and peer review."

In the meantime, Dr. Leicht thought physicians should insure that PSROs react to federal guidelines as loyal adversaries. Also, he felt that the health data center should be chosen for its independence of all agencies requesting health data.

Independence of the data collection agency, mentioned by Dr. Jesse and underscored by Dr. Leicht, was also the focus of remarks by James Kretzschmar of Blue Cross of Northeast Ohio. Mr. Kretzschmar felt the data

When impotence due to androgenic deficiency

is driving them apart



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Android®-25 ORAL Tabl

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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collection agency should have control of the data and maintain its confidentiality. He stated there must be guidelines on the kind of data collected, the time limit for collection, and the use of the data.

The symposium was sponsored by the Medical Advances Institute, The Ohio State University College of Medicine, and The Ohio Association of Areawide Health Planning, Inc.

OSMA Council Endorses Scholastic Trainers Group

Following a recommendation by the Joint Advisory Committee on Sports Medicine, OSMA Council has endorsed the newly formed Ohio High School Athletic Trainers Association (OHSATA).

Spearheading development of the new organization is Glen Foster, head athletic trainer at Fremont Ross High School. Foster explained that the OHSATA will initially include adult, fulltime athletic trainers. Student trainers and parttime trainers will be considered for membership following the organizational phase.

Foster explained that the primary goal of the OHSATA is to improve the quality of health care pro-

vided for Ohio high school athletes by promoting the profession of athletic training in high schools. He outlined the following functions of the OHSATA:

1. To promote programs which will improve the quality of health care for participants in Ohio high school athletic programs.
2. To promote the profession of athletic training in a public-relations sense throughout Ohio.
3. To promote professional growth both individually and collectively for high school athletic trainers throughout Ohio.
4. To provide proper trainer/medical coverage for all state high school tournament events.

As a result of a recent OSMA sports medicine survey sent to all Ohio high schools, Foster reported that he has data on the athletic trainer situation for approximately 87 percent of the state's high schools. He pointed out that approximately 60 full time, adult trainers have been identified through the survey.

Pending final approval by the Ohio High School Athletic Association, Foster hopes that the OHSATA will be under the "wing" of the OHSAA as are the various high school coaches associations.

(NEWS continued on page 12)

Anabolic Stimulant Increased Muscular Tone Osteoporosis

EACH ANDROID-G TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg
Methyltestosterone	1.25 mg
L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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Android-G

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Doctors' Dining Clubs

The Beginning of Continuing Medical Education

Charles W. Pavey, M.D.

Prior to the establishment of medical societies, one of the best and most popular means of sharing experiences and ideas was through doctors' dining clubs. These venerable groups, dating back to colonial days and even earlier eras in Europe, were the forerunners of our medical organizations.

Physicians tend to forget that modern means of communicating and disseminating medical knowledge have not always existed. Today's multitude of medical societies, specialty societies and super-specialty societies and limitless medical publications, tapes, and television programs erase thoughts of earlier days. Then medical publications with nationwide circulation were relatively few, and the state and national medical associations met once a year. The local academy of medicine met weekly with most or all of the presentations coming from local members. There was less to know then, to be sure, but the comparatively primitive means of communicating new knowledge made that knowledge harder to come by.

Club members felt they were raising the standards of the profession and, therefore, attempted to be selective

about who was admitted to membership. Prospective members were screened for training, reputation, character, and perhaps personality. The meetings were intended as a place to exchange ideas, introduce new methods and instruments, and keep abreast of developments over the broad spectrum of medical practice. Some of the earliest such organizations had as one of their functions sharing the cost of books and periodicals. This marked the beginning of medical libraries. Some such groups eventually became local medical societies and became licensing bodies.

Not too much is known about the oldest of such groups. They have received relatively little attention from medical historians, probably because of a paucity of available research information. So far as is known, the oldest such group in this country was the Physicall Club founded in Boston in 1735. Its career was relatively short. Others were formed or attempted in New Haven, Philadelphia, and South Carolina.

In 1760, seventeen physicians founded a dining club in New Brunswick which evolved into the New Jersey



The first American House, located on the northeast corner of High and State Streets in Columbus. Photo courtesy of the Ohio Historical Society.



Thanksgiving Day, 1859, menu of the Burnet House, a Cincinnati inn. Photo courtesy of the Ohio Historical Society.

State Medical Society. This group listed among its guests such personages as George Washington, Ben Franklin, John Adams, Alexander Hamilton, and the Marquis de La Fayette.

As these small dining clubs evolved into official county and state medical societies, the need for the smaller groups would seem to diminish. But the clubs continued to thrive despite the burgeoning volume of medical literature, communications, and societies. These more recent clubs are almost unknown to the public and even to many physicians, but they do provide opportunities for the exchange of ideas in a relaxed and friendly atmosphere.

Format and procedure in the new dining clubs vary widely and change with the times. Some clubs are quite formal and others equally informal. Some groups are kept quite small, a limit of 12 being a popular size. Meeting places range from members' offices and homes to taverns and clubs. In some, the host physician provides the repast, although quite frequently that responsibility falls to his wife; most commonly perhaps, the members eat in private dining rooms in public or semi-public facilities.

There are a goodly number of such clubs still functioning throughout Ohio, but they are so unobtrusive that information about them is scarce. Cleveland is thought

to have a few and Columbus has at least four: the Medical Review Club, the 41-year-old Medical Forum, The Medical Symposium, and ROMA (The Review of the Medical Arts).

The Medical Review Club is thought to have been founded shortly before World War I by Jonathan Forman and Ivor Clark. The Medical Forum was established in 1934, The Medical Symposium in 1951 or 1952, and ROMA about ten years later.

The general format is similar in all of them. All have about nine meetings a year with none occurring during the summer. Generally, there is at least one formal, social affair, which includes the spouses, and an outing or picnic, which may or may not include spouses. In the Medical Forum, a secretary is chosen each year by lot from the names of those who have not previously served in office. The next year this physician becomes vice-chairman and the third year chairman. The other Columbus groups use a similar procedure, but Symposium chooses their secretary through a nominating committee and an election.

All four clubs have both "town" and "gown" representation although no special effort is directed at keeping a balance, and all try to maintain a reasonable representation among the various fields of medicine. Twenty-five to 35 is the usual limit on membership, and the roster is usually full or nearly so. In a general way, most of the programs are scientific and are presented by the members in a loose rotation but there is considerable flexibility in this regard. Most clubs have provision for emeritus or inactive members on an optional basis after age 65, and there is usually an attendance requirement that is more apt to be honored in the breach than in the observance. Since the clubs are usually good-humored, easy-going, friendly organizations, the constitution is rarely given strict interpretation and members need little urging to get them to attend. All members seem to hold the camaraderie in high esteem as well as the opportunity for some expansion of knowledge into other disciplines. The Medical Review Club even stipulates that a prospective member



The dining room of the Columbian House located in Water-ville, Ohio. Photo courtesy of the Ohio Historical Society.

(continued on page 12)

Doctors' Dining Clubs (continued)

should be considered not only for his professional attainments but from the standpoint of his desirability as a dinner companion as well.

Doctors are not the best recordkeepers and there is a tendency for the organization minutes and other records of remote years to become lost, creating a serious problem for the would-be historian. This problem should engage the attention of the membership to the end that an archivist be designated and the running historical account of the organization not only be kept up-to-date but on file in more than one location.

Other doctors' dining clubs are invited to send information about their groups to *The Ohio State Medical Journal* which will compile a record of them, however meager, for the help of future historians.

Charles W. Pavey, M.D., F.A.C.S., practices medicine in Columbus. He is Emeritus Clinical Professor of Obstetrics and Gynecology at The Ohio State University College of Medicine, his alma mater. Dr. Pavey, a Diplomate of the American Board of Obstetrics and Gynecology and Fellow of the American College of Surgeons, is Past-President of the Academy of Medicine of Columbus and Franklin County, the Association of American Physicians and Surgeons, and The Medical Forum.

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NEW
MEMBERS

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during November, 1975. List shows name of physician, county, and city in which he is practicing or in which he is taking postgraduate work.

Belmont (Bellaire)
Samuel Lewis

Cuyahoga (Cleveland)
James W. Dietz
Wilfrido C. Reyes

Defiance (Defiance)
Sujaritchan Noparat

Lucas (Toledo)
Ronald S. Shapiro

Mahoning (Youngstown)
Ali F. Azimpoor
Bohumila Slabochova

Montgomery (Dayton)
Alan B. Ashare
Bruce J. Bernie
Barry Blackwell
Parkash V. Goel
Thomas G. Thornton

news

(continued from page 9)

Thirty-seven Drugs Introduced
In Period 1973 Through 1974

Thirty-seven new drugs were introduced in the United States during 1973 and 1974 in comparison with the previous two-year period during which 25 were introduced. Mind-altering drugs lead the list of new drugs with 18.8 percent of the total. Second were anti-infective products with 17.2 percent, and third were drugs to treat heart problems with 14.2 percent.

Paul de Haen, who issued the report on drug introduction, stated, "Today's new drugs are much more thoroughly researched before introduction than those offered in the past. Consequently, the physician can prescribe them with greater confidence and benefit for his patient. But there is never a guarantee for complete safety, because modern, highly potent drugs may produce unexpected toxicity that can only be discovered by constant watchfulness in the daily practice of the physician."

De Haen also noted that of the thousands of drugs available, only 200 accounted for 68 percent of all new and refill prescriptions.

obituaries

Leopoldo Banuelos, M.D., Vienna, West Virginia; Universidad Nacional Autonoma de Mexico, Mexico, 1955; age 48; died August 11; member of OSMA and AMA.

Thurston K. Batson, M.D., Dayton; Case Western Reserve University School of Medicine, 1948; age 50; died November 13; member OSMA and AMA.

Ogden H. Baumes, M.D., Cincinnati; University of Cincinnati College of Medicine, 1928; age 72; died October 30; member OSMA and AMA.

Walter A. Engel, M.D., Naples, Florida; University of Kansas School of Medicine, 1926; age 73; died November 9; member OSMA and AMA.

Warren L. Hogue, M.D., Akron; Northwestern University Medical School, 1920; age 80; died November 10; member OSMA and AMA.

Jack Meltzer, M.D., Cleveland; St. Louis University School of Medicine, 1934; age 67; died November 13; member OSMA and AMA.

Claude E. Price, M.D., Toledo; Case Western Reserve University, 1908; age 98; died November 1; member OSMA and AMA.

Reginald S. Rilling, M.D., Salt Lake City, Utah; Case Western Reserve University School of Medicine, 1928; age 73; died October 12; member OSMA and AMA.

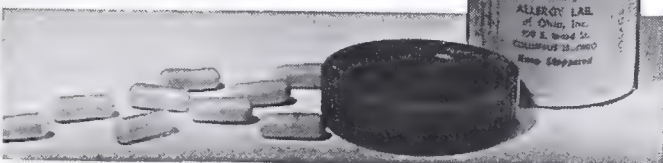
Ervin S. Ross, M.D., Cincinnati; University of Cincinnati College of Medicine, 1934; age 73; died January 1975; member OSMA and AMA.

Margaret Tucker, M.D., Cleveland; Rush Medical College, 1934; age 68; died October 30.

Edward R. Werner, M.D., Dayton; Ohio State University College of Homeopathic Medicine, 1917; age 81; died September 14; member OSMA and AMA.

T. Rees Williams, M.D., Columbus; Ohio State University College of Medicine, 1912; age 89; died November 20; member OSMA and AMA.

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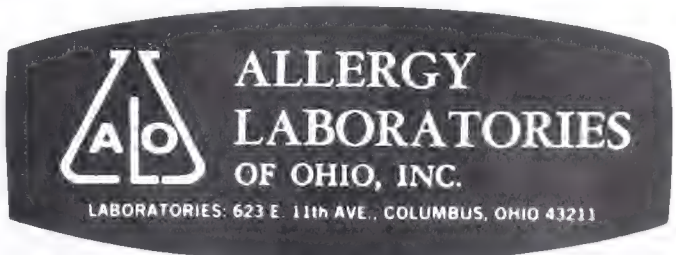
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COLLEAGUES IN THE NEWS . . .

Ninety-three Physicians Presented OSMA 50-Year Awards

During 1975, the Ohio State Medical Association honored 93 physicians who have completed a half century or more of service to their patients, to the public health and welfare, and to the principles of the art and science of medicine. The 50-Year Awards were presented each physician at various county academy meetings. Recipients are listed below according to county:

BUTLER (Hamilton)	Shirley Armstrong
Kurt E. Lande	(Cincinnati)
Neil Millikin	John A. Ferguson
COLUMBIANA (Sebring)	(now of Florida)
Lea A. Cobbs	Emerson P. Shepard
CUYAHOGA (Cleveland)	(now of Florida)
James R. Bell	GEAUGA (Burton)
Stanley E. Brown	William A. Reed
George F. Deutsch	HAMILTON (Cincinnati,
Louis J. Eisenberg	except where noted)
Alexander N. Freed	Robert A. Lyon
Bruno Gebhard	Warren K. Marvin
Isaac E. Halperin	William O. Ramey
Joseph V. Heimann	George Renner, Jr.
Walter Heymann	William L. Roach
Roland S. Jauch	William H. Rohdenburg
Jacob M. Kahan	Irving H. Schroth
Jay C. Kloepper	Stanley D. Simon
Victor C. Laughlin	Arthur W. Wendel
Hyman P. Levin	(Batavia)
John J. McCarthy	Clifford L. Keidel
Curt M. Nemrow	(Cleveland)
Anthony J. Perko	Ivan S. Johnson
Benjamin P. Persky	(now of Florida)
Hans Seidemann	Conrad O. Ranger
Emerald B. Spencer	(now of Michigan)
Myron A. Weitz	HARDIN
Charles H. York	Robert F. Schultz
Joseph C. Root	(now of Florida)
(now of Florida)	JEFFERSON (Toronto)
Norton H. Bare	John W. Young
(now of Nebraska)	LICKING
DEFIANCE	Roland W. Jones
John F. Holtzmuller	(now of Alliance)
(now of Michigan)	LORAIN
FAIRFIELD (Lancaster)	George A. Hoke
Chester P. Swett	(now of Arizona)
FAYETTE (New Holland)	LUCAS (Toledo)
Marion D. Gamble	Alpha R. Klopfenstein
FRANKLIN (Columbus, except	Milton A. Strawbridge
where noted)	(now of Florida)
Carl M. Basnett	MAHONING (Canfield)
Dorence S. Cowles	John M. Cavanaugh
Louis N. Jentgen	Walter S. Curtis
Ruskin B. Lawyer, Sr.	(now of New York)
Willis B. Merrill	MEDINA
(Reynoldsburg)	Vaughn L. Hartman
	Roland L. Mansell

Charles S. Stone
MONTGOMERY (Dayton)
 Ralph O. Cass
 Marion W. Coleman
 Charles A. Hueneker
 David Kushnir
 Edgar A. Sherk
MUSKINGUM (Zanesville)
 Walter L. Cruise
PIKE (Waverly)
 Paul S. Yocum, Jr.
PORTAGE (Kent)
 John R. Turner
RICHLAND
 Erling A. Smedal
 (now of Arizona)
SCIOTO (Portsmouth)
 Francis E. Kulcsar
STARK (Canton, except
 where noted)
 Arden R. Basinger
 Harry W. Beck
 Abe A. Fisher
 Anne W. Robinson
 Ernest R. Valentine
 (Alliance)

SUMMIT (Akron, except
 where noted)
 Frank H. Bly
 Samuel H. Eisenberg
 Joseph D. Hayden
 John F. Henderson
 Vincent C. Malloy
 Alexander P. Ormond
 James T. Villani
 Edward L. Voke
 Byron E. Neiswander
 (Doylestown)
 John Bakos
 (now of California)
 Robert T. Allison, Jr.
 (now of Maryland)
TRUMBULL (Warren)
 Patrick J. Fusco
 Sigmond J. Shapiro
TUSCARAWAS (Gnadenhutten)
 William C. Roche
WARREN (Lebanon)
 James H. Arnold
Wood (Perrysburg)
 Paul F. Orr

September marked the dedication of the B. J. Allison Health Center, home of the Jackson County Health Department. The center is named in memory of **DR. BRINTON J. ALLISON**, who served the county as health commissioner from 1933 to his death in 1974. Work toward the \$422,075 center was set in motion during Dr. Allison's lifetime.

Dr. Carl J. Greever, present Health Commissioner, said of Dr. Allison: "He led the department through many crises and built the department into a strong unit capable of coping with epidemics of the early days and the demand for services we see necessary today to keep a community healthy."

Peebles recently dedicated the **ROBERT B. ELLISON** Park, honoring Dr. Ellison for his service to the community over a period of 41 years. The park was financed by a grant from the Department of Natural Resources and matching funds from the town. Dr. Ellison is a member of the American Academy of Family Physicians.

Northeastern Ohio Universities College of Medicine has appointed two council chairmen. **HOWARD J. IGEL, M.D.**, has been named Chairman of the Pathology Council; and **JOHN C. JOHNS, M.D.**, has been named Chairman of the Council of Coordinators of Graduate

Medical Education. The councils of chiefs of medical services at community hospitals associated with the new college are organizing, developing, and implementing undergraduate clinical teaching programs of the college.

Dr. Igel has been Director of Infectious Disease and Virology at Children's Hospital in Akron since 1968, Chief Pathologist since 1972, and Chief of Staff in 1975-1976.

Dr. Johns is Chairman of the Department of Medical Education at Akron General Medical Center, where he won the Teacher of the Year Award in Internal Medicine in 1973. He is also a consultant in the treatment of diabetes and a member of the Special Admissions Committee for Fifth Pathway students at Case Western Reserve University.

WALLACE N. JENSEN, M.D., an internationally recognized authority on disorders of the blood, particularly sickle cell anemia, has been appointed Chairman of the Department of Medicine at Albany Medical College and Physician-in-Chief at Albany Medical Center Hospital. From 1967 to 1969, Dr. Jensen was Professor of Medicine and Vice-Chairman of the Department of Medicine at The Ohio State University College of Medicine.

ERNEST W. JOHNSON, M.D., Professor and Chairman of the Department of Physical Medicine of The Ohio State University College of Medicine, has been appointed to the additional post of Associate Dean for Ambulatory Programs. Dr. Johnson has been on the Ohio State faculty since 1954 and has headed the Department of Physical Medicine since 1963.

Dr. Johnson is President-Elect of the Association of Academic Physiatrists, a Director and Past-President of the American Association of Electrodiagnosis and Electromyography, and Past-President of the Ohio Society of Physical Medicine and Rehabilitation. He is also a diplomate of the American Board of Physical Medicine and Rehabilitation.

CAPTAIN WALTER W. KEYES, M.D., was among 180 members of the Ohio National Guard's 178th Tactical Fighter Group who deployed from the Springfield Municipal Airport to Ramstein Air Base, Germany, in October. Dr. Keyes participated in the North Atlantic Treaty Organization's annual fall "Reforger" exercise.

Lancaster physician **JACK L. KRAKER, M.D.** is the new President of the Fairfield County Medical Society. Dr. Kraker is currently serving his second term as President of the Fairfield County Heart Branch and also serves as medical director of Tarhe Shrine Club of Hocking, Perry, and Fairfield Counties. He is also a staff physician at Lancaster-Fairfield County Hospital.

JACK H. MEDALIE, M.D., has been named Chairman of Case Western Reserve University's new Family Medicine Department. Projects for the new department include establishing two family practice units at University Hospitals and Cleveland Metropolitan General Hospital and establishing other training programs in family practice in community hospitals, health centers, and group practices.

"Case Western Reserve is the first major U.S. medical school to decide to go all-out in establishing a department of family medicine," said Dr. Medalie.

Dr. Medalie had been Chairman of Tel Aviv University's Family Medicine Department, Israel.

JOHN D. MORLEY, M.D., Director Emeritus of the Akron Health Department, is the 1974 recipient of the Bert A. Polsky Humanitarian Award. This prestigious award has been presented to only six other Akron area leaders. It was established in memory of Bert A. Polsky, civic, cultural, and business leader.

CHARLES H. RAMMELKAMP, JR., M.D., F.A.C.P., of Cleveland, was an honored guest at the West Virginia and Western Pennsylvania Regional Meeting of the American College of Physicians (ACP). Dr. Rammekamp, who is Regent of the ACP, reported on the activities of the 30,000-member college.

BARNET R. SAKLER, M.D., of Cincinnati, has been elected President of the Joint Commission on Allied Health Personnel in Ophthalmology. The commission is the national authority representing American and Canadian ophthalmology in the accreditation, examination, certification, and continuing education of ophthalmologic medical personnel.

Dr. Sakler is Immediate Past-President of the Ohio Ophthalmological Society, a member of OSMA's Committee on Eye Care, Past-President of the American Association of Ophthalmology, and a member of the University of Cincinnati College of Medicine faculty.

The American College of Physicians (ACP) has announced the names of physicians who have been made Fellows of the 60-year-old international society which represents specialists in internal medicine and related fields. The 325 new Fellows were elected at a recent meeting of the Board of Regents.

Ohio physicians elected to the ACP are **GERALD F. BOWLING, M.D.**, Akron; **FUHEID S. DAOUD, M.D.**, **RICHARD T. MARNELL, M.D.**, and **HAMIO SAHEBJAMI, M.D.**, Cincinnati; **GERALD W. KING, M.D.**, **ERNEST L. MAZZAFERRI, M.D.**, and **JOHN F. WARNER, M.D.**, Columbus; **DALE R. HINES, M.D.**, Dayton; **FREDERICK W. KUNKEL, M.D.**, Poland; and **P. GREG RHODES, M.D.**, Youngstown.

Secretary-General of the ACP is **RICHARD W. VILTER, M.D.**, of Cincinnati.

The 33,000-member ACP dedicates itself to upgrading medical care, teaching, and research.

Claims Philosophy of the Joint Underwriting Association

Layton C. Severson, Claims Manager

There is a great deal of speculation and concern within the medical profession regarding how the Joint Underwriting Association (JUA) will handle claims and what their claims philosophy will be regarding professional negligence claims in Ohio.

The claims philosophy of the JUA was established in one of the early Board of Governors' meetings. It is the responsibility of the claims committee and the claims manager to adhere to the policy. In a unanimous decision, the Board of Governors stated that the claims for alleged professional negligence will be viewed with a strongly defensive trend and will be carefully analyzed before any consideration of payment is made.

It is the JUA's belief that any allegations toward medical negligence must be investigated in depth and that the involved insured physician must be a prime source of that investigation. The physician will be kept posted as to the results of each and every action brought against him which is being handled by the JUA.

A great deal of discussion has gone on over the fact that the involved physician no longer has the contractual right to approve or disapprove settlement of any alleged claims against him. I personally find no fault with this change in contract, and I seriously doubt that any insured physician will have any trouble with this contract item as claims progress.

As a practical matter, it is difficult to visualize any substantial difference of opinion concerning the contract item of the right to accept or deny a claim on the part of a physician. Bearing in mind that the physician will be a determining factor in any investigation of the alleged medical act that produced the court action, it is inconceivable to me that we would take a stand against our insured physician's opinion on a claim of any size. However, it should be remembered that the majority of differences between an insurer and an insured physician as to accepting or rejecting liability usually are over very minor cases. It is our belief that the minor cases should be fought just as hard as the serious exposures so that we show a united front in our claims position.

We are very cognizant of the fact that the JUA is essentially funded by physicians and hospitals that are actively holding policies of the association. Therefore, we believe that we should make the best defense available on all claims regardless of their magnitude. It is our intention to handle all negotiations and formulate all legal and medical decisions from our claims office in Columbus. Essentially, what this means is that on each alleged claim that has some potential merit, we will assign an investigator to determine the facts. He will fully investigate the

file under our direct guidance. Based upon these facts and the opinion of our insured, as well as competent medical and legal evaluation of the file, we will be able to present a much more unified claims handling procedure and our philosophy of being defense oriented can be controlled to a much greater degree.

While I wish to stress the defense position of the JUA, I do not want to infer that claims with merit will not be negotiated and settled at the earliest possible time. However, it should again be remembered that we intend to actively seek the involved physician's opinion before the final decision on any claim is made. Therefore, we expect to evaluate each claim on its own merits and not on a broad spectrum of statistical data.

One of the most difficult areas of investigation of a professional negligence claim seems to be in the communication with and the arranging of a meeting between the investigator and the involved physician. This is due largely to the schedules containing many and varied commitments which are kept by physicians. It is our hope that when the JUA receives notice of a potential claim, the first conversation will be between either the insured or his agent and the JUA claims office. During that initial telephone conversation, we hope to gain general understanding of what the claim consists and to establish a time and place for the JUA investigator and physician to meet.

If we can accomplish this meeting between the insured and the investigator at an early date and coordinate future investigative efforts, I believe that we can satisfy the active requirements of the file at a much more rapid pace. If the full investigation of facts can be carried out before key witnesses move, personnel changes occur, and so forth, the JUA can determine liability at a much earlier date, even though we may have to wait for medical evaluations to determine the full extent of injuries or ongoing disabilities.

In summary, it should be noted that the JUA claims philosophy will be one composed of thorough investigation and coordination and communication with our insured. The JUA will actively seek the insured's input regarding liability and medical injuries as well as the determination of future and ongoing injuries or disabilities. In the event that there are any inquiries regarding the JUA claims handling procedures or our philosophy as an association, please write or call Layton C. Severson, Claims Manager, Ohio Medical Professional Liability Underwriting Association, 1880 East Dublin-Granville Road, P.O. Box 2638, Columbus, Ohio 43216. Telephone (614) 891-5400; Ohio WATS 1-800-282-8817.



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Found useful in the management of vertigo* associated with diseases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. Chewable Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Antivert®/25 (meclizine HCl) 25 mg. Tablets for vertigo*

Documented bioavailability...
Regimen flexibility

q.i.d. or q 6h immediately after or between meals

E-Mycin[®]

erythromycin enteric-coated tablets, Upjohn

250 mg

Formulated for quality...
Priced for economy.

Upjohn

See facing page for brief summary of prescribing information.

E-MYCIN® TABLETS — 250 mg — For Oral Administration (erythromycin enteric-coated tablets, Upjohn)

E-Mycin Tablets (erythromycin enteric-coated tablets) are specially coated to protect the contents from the inactivating effects of gastric acidity and to permit efficient absorption when administered either immediately after meals or when given between meals on an empty stomach.

Indications: *Streptococcus pyogenes* (group A beta-hemolytic streptococci): Upper and lower respiratory-tract, skin, and soft-tissue infections of mild to moderate severity. Parenteral benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever. When oral medication is necessary (because the parenteral route is contraindicated) or if there is known allergy to penicillin, the following recommendations made by the American Heart Association apply: 1) Oral penicillin G or V (where no allergy exists)—This is the drug of choice. Give for a minimum of 10 days; 2) Erythromycin—Give for a minimum of 10 days. A few strains of streptococci resistant to erythromycin have been reported.

Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.) *Staphylococcus aureus*: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.

Diplococcus pneumoniae: Upper respiratory-tract infections (e.g., otitis media, pharyngitis) and lower respiratory-tract infections (e.g., pneumonia) of mild to moderate degree.

Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.

Treponema pallidum: Infections due to this organism.

Corynebacterium diphtheriae and *Corynebacterium minutissimum*: As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extra-enteric amebiasis requires treatment with other agents.

Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

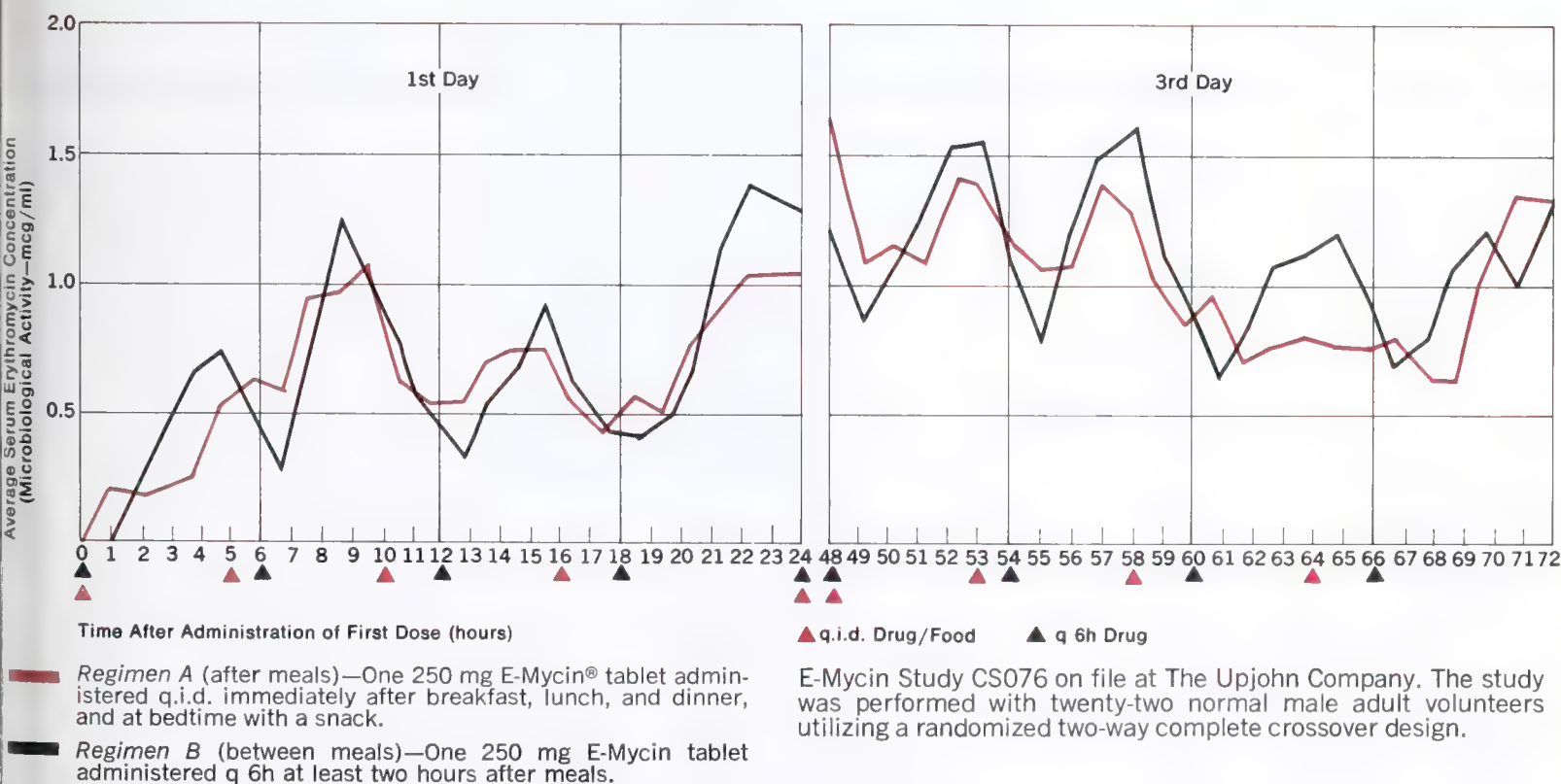
Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of non-susceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdose: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdose should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.

How supplied: 250 mg—in bottles of 100 and in unit-dose packages of 100 enteric-coated tablets. Caution: Federal law prohibits dispensing without prescription.

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No statistically significant difference in area under the curve was observed from 0-24 hours or 48-72 hours at the 95% confidence level ($p > .05$).

The data clearly demonstrate that E-Mycin, when administered q.i.d. immediately after meals, produced average serum levels equivalent to those obtained when the drug was administered q 6h at least two hours after meals.

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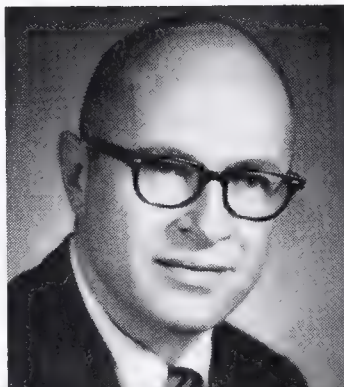
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MED B-7-5

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
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The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Opinion
&
Dialogue

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebotrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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Experience in Management of Hyaline Membrane Disease

Gerald H. Katzman, M.D.

Survival rate for neonates with hyaline membrane disease in Northwest Ohio during a one-year period (October 1973-October 1974) was reviewed. Survival in a new intensive care facility serving Northwest Ohio was encouraging (85 percent inborn, 80 percent outborn). Survival in infants above 31-weeks' gestation was 95.5 percent. Mortality was more frequent in the immature infant. Intraventricular hemorrhage was particularly frequent in this immature group.

At present, management of the pregnancy at risk involves close attention to in utero asphyxia (fetal monitoring). Expert resuscitation of depressed infants is important to preserve, as much as possible, surfactant synthesis which may be compromised by hypoxia, acidosis, and hypercarbia.

If the infant develops a respiratory score (Downe's score) greater than four which persists, umbilical artery catheterization is carried out. Stopcocks are changed daily thus maintaining sterility. Oxygen is delivered by oxyhood. If the PaO_2 is less than 60 with FiO_2 of 70 percent, nasal continuous positive airway pressure (CPAP) is instituted. A rising PCO_2 , pH less than 7.20, and persistent hypoxemia may make endotracheal intubation and mechanical ventilation mandatory. The infant's chest should be auscultated frequently for patent ductus arteriosus presence. Close attention to blood pressure, electrolytes, blood sugar, hemoglobin and hematocrit, serum protein, calcium, and bilirubin levels are important. Caring for infants in a neutral thermal environment is an essential part of newborn care.

IT HAS BEEN DEMONSTRATED that the delivery of intensive care to immature or otherwise compromised newborn infants has a salutary effect on their subsequent survival and, indeed, on the quality of their survival.^{1,2} In July of 1973, the organization of a regional intensive care nursery to serve Northwest Ohio was begun at The Toledo Hospital. This report deals with the experience with hyaline membrane disease from October 1973 to mid-October 1974 in this facility.

Fifty-four cases of hyaline membrane disease* which occurred in the study period were reviewed. These included infants born at The Toledo Hospital (inborn) and those transported by ambulance from surrounding community hospitals (outborn). Table 1 indicates the survival and distribution of these infants.

*Diagnosis of hyaline membrane disease was made when there was an x-ray film showing hypoaeration, air bronchograms, and reticulogranularity along with a suggestive clinical course.

The weight distribution and survival in these 54 infants is illustrated in Figure 1. Survival as it relates to gestational age is shown in Figure 2. Although multiple factors are responsible for improved survival of infants with hyaline membrane disease in recent years, the use of nasal continuous positive airway pressure (CPAP) in treating the moderately affected infant³ and the increased expertise in supporting the newborn infant with respiratory failure (rising PCO_2 and pH less than 7.20) by means of mechanical ventilation,^{4,6} are the two major clinical advances that are felt to be operative in this series.

It is generally accepted that optimal management of the high risk neonate involves their in utero transport to the facility which will ultimately care for them. Since

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this “perinatal approach” is in its early development, the majority of the cases of hyaline membrane disease in this report were outborn. The time of referral in relation to mortality is illustrated in Table 2. It seems that the highest rate of mortality occurred in the 4- to 13-hour group. It is true that the numbers are small. However,

TABLE 1. Survival of Hyaline Membrane Disease Patients

	No. of Patients	No. of Survivors	Percent of Survival
Inborn	13	11	85
Outborn	41	33	80

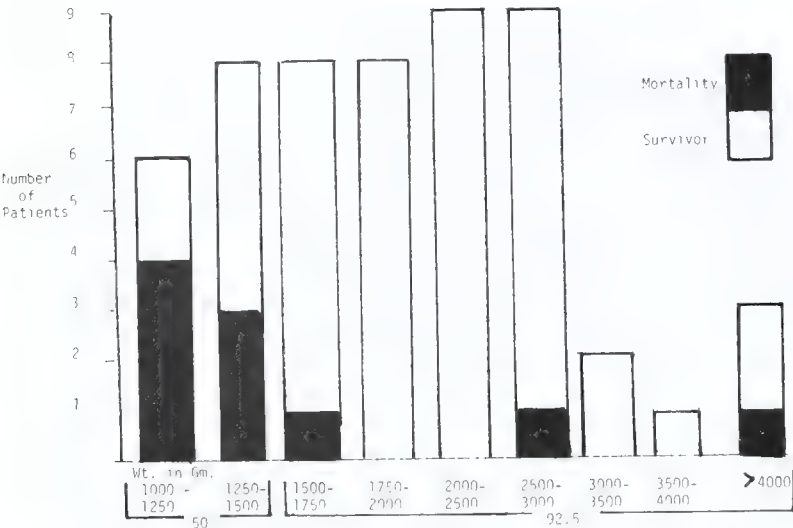


FIG. 1. Survival rate of hyaline membrane disease patients based on birth weight.

prominent in the mortalities are immaturity and asphyxia at birth or hypoxia in the early hours of life.

The two deaths in the infants weighing more than 2000 gm present an interesting problem for future research. One infant was the product of an insulin-dependent diabetic mother. The infant developed progressive hypoxemia and hypercarbia in spite of the positive airway pressure and mechanical ventilation. A grade III/IV systolic murmur along the left sternal border was prominent throughout this infant’s course. One wonders if persistent fetal circulation with right-to-left shunting through the ductus arteriosus and resultant pulmonary hypoperfusion and compromise in surfactant synthesis

TABLE 2. Mortality as Related to Time of Arrival

	Arrival at Regional Unit				
Hours of life	<4	4-7	7-13	13-24	>24
Patients	7	14	11	4	5
Mortality	1	4	3	0	0

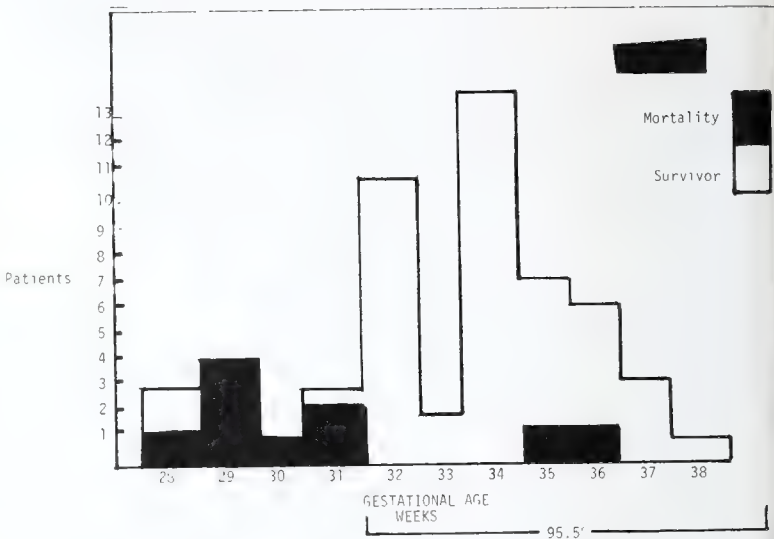


FIG. 2. Survival rate based on gestational age.

would explain the pathogenesis here. If this is so, could steps be taken to identify similarly affected infants and therapeutic measures developed to relieve the vasoconstriction of the pulmonary arterioles? Postmortem examination in this infant showed lungs which sank in water and microscopically demonstrated atelectasis and four-plus hyaline membranes.

The other infant, whose weight was above 2000 gm and who died, was severely asphyxiated at birth and required positive pressure resuscitation. Unfortunately, there was not thought to be an indication for fetal monitoring in this case although, retrospectively, in utero asphyxia was most probably present. Very high PIPs* during mechanical ventilation (55 cm water) did not relieve the hypoxemia or the hypercarbia. Reading of chest x-ray film was consistent with hyaline membrane disease. Permission for postmortem examination could not be obtained.

Twenty-two percent of the infants were born by cesarean section. The indications for these sections are listed in Table 3. From this data, it is apparent that the educated use of amniocentesis and lecithin sphingomyelin (L/S) ratio determination could serve to prevent some cases of hyaline membrane disease.

Two forms of assisted ventilation were used, when thought to be indicated, in this group of infants. Nasal CPAP was generally instituted when the PaO₂ was less than 60 with FiO₂ of 70 percent.² (See Table 4.)

All nasal CPAP “failures” were mechanically ventilated. Criteria for mechanical ventilation included rapidly rising PCO₂ with pH less than 7.20 or persistent hypoxemia (PaO₂ less than 40). Mechanical ventilation was carried out after endotracheal intubation with a variety of both volume-controlled and pressure-regulated respi-

*PIP - Peak inflation pressure

rators (Servo 0900™, M-A-1 Bennett™, Baby Bird™). Positive end expiratory pressure (PEEP) of 4 to 5 cm of water was always used. The peak inflation pressure (PIP) and the volume of gas delivered by the respirator were regulated to maintain the PCO₂ at less than 45 but greater than 35. A total of 24 patients received respirator therapy. Of these, nine patients (39 percent) developed pneumothorax. The incidence of pneumothorax in relation to the PIP is shown in Table 5. The increased incidence of pneumothorax with increasing PIP is readily apparent. All pneumothoraces occurring during mechanical ventilation were treated by insertion of 12F argyle disposable infant chest tubes in the second interspace in the midclavicular line. The chest tubes were connected to underwater seal and 20 cm of negative pressure was applied. The risk of pneumothorax should not retard one from increasing the PIP in the face of hypoxemia (PaO₂ less than 50 with 100 percent FiO₂), significant hypercarbia (PCO₂ greater than 60), and pH less than 7.20.

The overall survival of the infants receiving ventilator therapy was 14/24 (58 percent). Infants who deteriorated very rapidly or were in respiratory failure on admission to the nursery were mechanically ventilated without a trial of nasal CPAP. It is interesting that from the eight "failures" of nasal CPAP, six infants (75 percent) survived after mechanical ventilation.

In the 12 infants who were demonstrated by x-ray film to develop interstitial emphysema, 11 developed pneumothorax, later.

Serum calcium was measured in 47 patients in this series. Of these, 34 patients (72 percent) were shown to have a serum calcium value of less than 7 mg/100 ml.

Three patients in this series developed signs of congestive heart failure secondary to patent ductus arteriosus. Two of these failed to respond to medical management and required operative ligation which was successful in both cases.

Of the ten patients that died, intraventricular hemorrhage was proven in three and suspected in two (falling

TABLE 5. Relation of Peak Inflation Pressure (PIP) to Occurrence of Pneumothorax

No. of Patients	PIP	Pneumothorax
4	25	1
3	30	0
5	31-35	2
2	36-40	2
4	>40	3

hematocrit but postmortem examination not performed).

Infection continues to be a problem. One case of *Pseudomonas septicemia* was encountered early in the study group. After this experience, all infants intubated were placed on appropriate doses of gentamicin, rather than kanamycin, along with penicillin. There persists, however, a problem with tracheitis and bronchitis. These are manifested by positive cultures obtained from secretions aspirated from the endotracheal tube after about 72 hours of intubation. The secretions often become thick and purulent in spite of systemic antibiotic therapy.

Three infants required tracheotomy* because of rising PCO₂ and increasing stridor after extubation. Removal of the tracheotomy tube was possible three to four weeks after it was inserted. All three infants left the hospital after the tracheotomy tube was removed.

Thirty-five of the patients developed a serum bilirubin level greater than 10 mg/100 ml. Thirty-three of these patients received special blue phototherapy. Thirty-six of the 54 patients were male (66.6 percent).

The morbidity in this group of infants is yet to be determined. Nevertheless, the normal growth and development noted to date in many of these infants, including the ones that have undergone mechanical ventilation, is most encouraging.

At present, management of the pregnancy at risk involves close attention to in utero asphyxia (fetal monitoring). Expert resuscitation of depressed infants is important to preserve, as much as possible, surfactant synthesis which may be comprised by hypoxia, acidosis, and hypercarbia.

If the infant develops a respiratory score (Downe's Score) greater than four which persists, umbilical artery catheterization is carried out (Figs. 3 and 4). Stopcocks are changed daily to maintain sterility. Oxygen is delivered by oxyhood. If the PaO₂ is less than 60 with FiO₂ of 70 percent, nasal CPAP is instituted. A rising PCO₂, pH less than 7.20, and persistent hypoxemia may make endotracheal intubation and mechanical ventilation mandatory. The infant's chest should be auscultated frequently for patent ductus arteriosus presence. Close attention to blood pressure, electrolytes, blood sugar, hemoglobin

TABLE 3. Indications for Cesarean Section in Hyaline Membrane Disease Patients

Indication	Sections
"Elective"	3
Abruptio placentae	1
Placenta previa	3
Cardiopulmonary distress	0
Repeat in labor	3
Uterine anomaly	1

TABLE 4. Experience with Nasal Continuous Positive Airway Pressure (CPAP)

Total	Failures	Success	Mortality
22	8	64%	2/22 (9.1%)

*Shiley Pediatric Tracheostomy Tube,® Size 00, Shiley Laboratories, Inc. Santa Ana, California 92705.

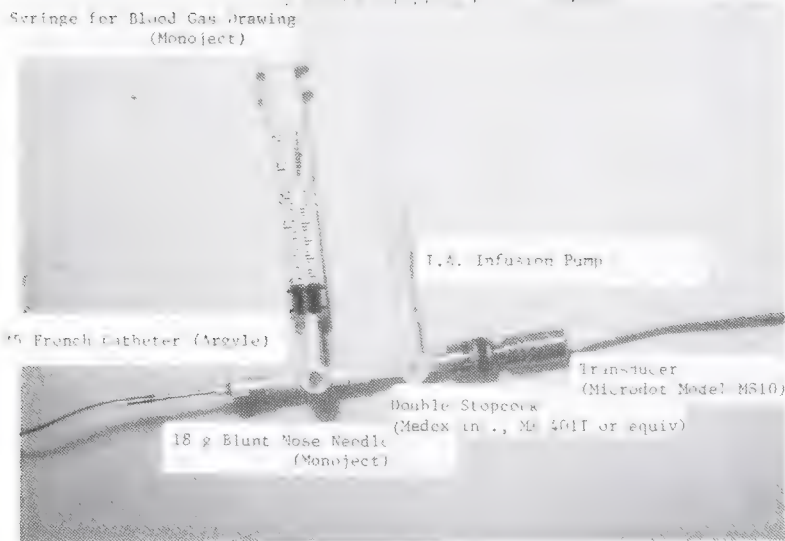


FIG. 3. Catheterization using #5 French umbilical artery catheter.

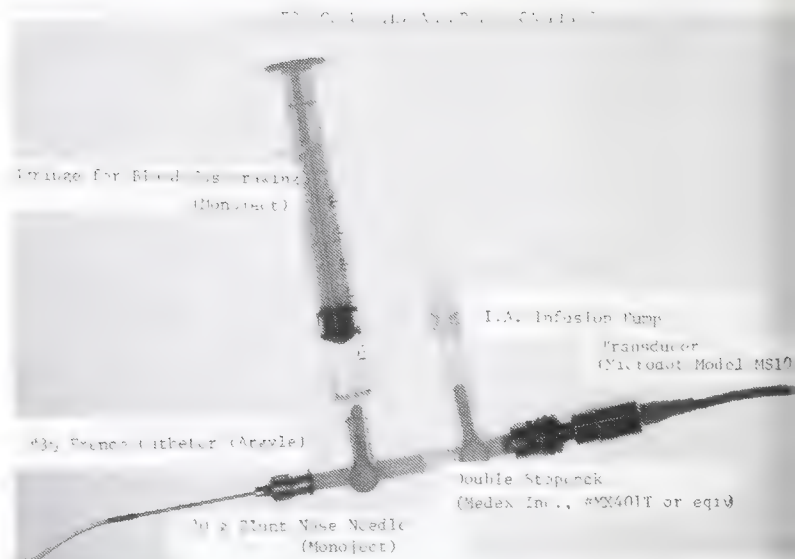


FIG. 4. Catheterization using #3 1/2 French umbilical artery catheter.

and hematocrit, serum protein, calcium, and bilirubin levels are important. Caring for infants in a neutral thermal environment is an essential part of newborn care.

There is every reason to believe that this comprehensive management will continue to benefit the majority of infants with hyaline membrane disease.

Acknowledgment: Special thanks to Mrs. Brenda Wilson for preparation of the manuscript and to the nurses in the intensive care nursery for their diligent efforts in caring for these critically ill infants.

References

1. Rawlings G, Stewart A, Reynolds EO, et al: Changing prognosis for infants of very low birth weight. *Lancet* 1:516-519, 1971.
2. Drillien CM: Later development and follow-up of low birth weight babies. *Pediatr Ann* 1:44-54, 1972.
3. Llewellyn A, Swyer P: "Assisted ventilation," in Klaus MH and Fanaroff AA (eds): *Care of the High-Risk Neonate*, Philadelphia, W B Saunders, 1973, p 152.
4. Gregory GA: Respiratory care of newborn infants. *Pediatr Clin North Am* 19:311-324, 1972.
5. Harrod JR, L'Heureux P, Wangenstein OD, et al: Long-term follow-up of severe respiratory distress syndrome treated with IPPB. *J Pediatr* 84:277-286, 1974.
6. Johnson JD, Malachowski NC, Grobstein R, et al: Prognosis of children surviving with the aid of mechanical ventilation in the newborn period. *J Pediatr* 84:272-276, 1974.



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Intravenous Use of Fructose in the Detoxification of Alcoholics

A Ten-Month Study

Harold Fishbain, M.D.
Tom McNamara
Marjorie Vasileff, R.N.
John Wing, Ph.D.

In an effort to conserve time and money, a ten-month study of the effect of intravenously administered fructose in alcoholic detoxification of patients in a mental hospital was made by the Mental Health Unit of Clark County, Ohio. The clinical results were somewhat positive, but the cost effectiveness was negligible.

THE MENTAL HEALTH SERVICES for Clark County has assumed the responsibility for alcohol detoxification in Clark County, Ohio until other resources become available. Currently, one third of the admissions are for alcohol detoxification. On a service with a capacity of 31 beds, well over 9,000 patient days per year, with an average census of 25 patients, the staff often is strained to take care of the load. We are always looking for ways to reduce the stress and strain on the staff and to reduce the average stay of the patients who

are admitted. The goals of this particular detoxification program are to help the person quickly resume a normal psychologic and physiologic state so he can become involved in our short-term, intensive education program, which provides at least some insight into his problem and prepares him for an after-hospital treatment program utilizing other resources available in the county. Because so many of these men and women are admitted to the mental health unit in lieu of jail, their condition often warrants seclusion, restraint, and quick detoxification for communicative and cooperative efforts on their part. This motivated us to try the use of fructose as a way of resolving some of the stress and strain of the alcoholics on our unit.

The Role of Fructose

In recent years, fructose has been presented as a substance which is helpful in the detoxification of alcoholics. Research had been done investigating the effects of glucose in alcohol detoxification. In 1937, Carpenter, et al¹ found that glucose increased slightly, but definitely, the rate of elimination in expired air. However, it had little, if any, effect on alcohol in the urine. In an experiment comparing glucose and fructose, Lundquist and

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Wolthers (1957)² observed that the oral administration of fructose increased the elimination of alcohol from the blood, in contrast to the oral administration of glucose.

In 1965, Tygstrup, et al³ began to investigate the effects of intravenous administration on the liver and the fructose effect. (The fructose effect is the increased velocity of elimination of alcohol.) They found that a dismutation reaction involving the reduction of fructose to sorbitol also contributes to the fructose effect. Concerning the effects of fructose on alcohol in the liver, they noted that an infusion of ethyl alcohol and fructose produces a 30 percent increase in blood flow and a 60 percent increase in oxygen uptake over the infusion of either of these substances alone. They also noted that fructose almost doubled the splanchnic uptake of fructose and a corresponding amount of polyol (mainly sorbitol) appearing in the hepatic veins, which was not found when there was an infusion of fructose alone. In their investigation, the infusion of alcohol, and fructose caused the splanchnic output of lactate and pyruvate to decrease by one-third and the splanchnic output of glucose to triple. As before, these effects did not take place with the infusion alone. Quantitatively, the most important effect discovered was the formation of glyceraldehyde from fructose. This formation made it possible to circumvent a limited step in the dehydrogenation of ethanol acetaldehyde, the dissociation of alcohol dehydrogenase, and reduced nicotinamide-adenine dinucleotide.

In 1972 and 1973, further experimentation of the intravenous administration of fructose took place. Brown, et al⁴ (1972) found that, in patients without other complications, fructose administration can shorten the alcoholic's stay in the emergency room by a few hours and can

reduce the period of intoxication. Such a reduction helped emergency room physicians to obtain history about medical emergencies from patients admitted in an unconscious state. However, these experimenters did report subjects complaining of nausea and upper abdominal pain lasting 10 to 20 minutes when a 40 percent fructose solution was used. Subsequently, the solution of fructose was dropped to 10 percent, and no further complaints were reported.

The findings of Kunian, et al⁵ (1973) supported those of Brown, et al.⁴ They found that only 1 out of 30 patients tested was not ambulatory in 2½ hours after being treated with 10 percent fructose. They also noted side effects, such as nausea and flushing in subjects, and reduced the concentration of the fructose. Furthermore, Dr. Kunian, et al, found that fructose-treated patients appeared more alert than most conventionally treated patients, and there were no signs of tremors or ataxia. The present study differed from the previously mentioned ones in that fructose was administered intravenously to alcoholics in a mental health setting instead of an emergency. The subjects usually are admitted to this facility for detoxification and alcoholism education. They were selected by alternating those chosen for the experimental group (35) with those for the control group (49) as they were admitted for detoxification (Table 1). Patients eliminated from the experimental group were those who refused the intravenous fluids and those too unmanageable to receive intravenous fluids. This accounts for the difference in the size of the groups.

Materials and Methods

Five hundred cc of a 10 percent solution of fructose in water was given at a rate of approximately 30 drops

TABLE 1. Comparison of Control and Experimental Groups Prior to Treatment

	Control		Experimental	Statistical Test*	Conclusion
Age	45.5	Mean Years	45.0	Mann-Whitney (z = .289†)	No difference
	44.5	Median Years	43.0		
Sex	8	Females	9	x ² (x ² = 1.2†)	
	41	Males	26		
	49	Total	35		
Cumulative Percentage in Each Degree of Intoxication Category					
Degree of intoxication	2.13	(1) Coma or stupor	3.03	Kolmogorov-Smirnov (D = 8†)	No difference
	10.64	(2) All faculties impaired	15.15		
	19.15	(3) All behavior incoordinated	24.24		
	40.43	(4) Clumsiness, loss of judgment	48.48		
	100.00	(5) Mild intoxication	100.00		

*Statistical tests described by Siegel⁶
†Not significant

per minute in the experimental group. As soon as the patient was steady on his feet, he was permitted to walk in the lounge or to the cafeteria if he desired. If he expressed hunger, he was fed whatever he could tolerate. This also was true in the control group. Once a patient was eating, he was able to follow the regular regimen of three meals daily and to partake of between-meal snacks, which were always available.

Upon admission, blood alcohol and glucose levels were determined in both groups. Both groups were observed and the following recorded: temperature, pulse, respiration, blood pressure, time of last drink, amount, kind of drink. An objective evaluation was made of the state of intoxication by the following criteria: (1) alcohol stupor or coma; (2) gross impairment of faculties; (3) incoordination affecting all behavior; (4) clumsiness, loss of judgment, staggering, slurred speech; and (5) degree of intoxication, lessened inhibitions. Patients were rated on a seven-point scale as to the degree of intoxication.

Observational notes indicating behavior changes were recorded every half hour for three hours. Notes were made in narrative form indicating the patient's level of consciousness, describing his speech, gait, and signs of withdrawal. Observations were recorded again after 8 and 24 hours.

In addition to these recordings made specifically for this project, our usual nursing observations were made on each shift and were tabulated each day. These denoted by a single numerical scale the patient's adjustment on the hospital unit (use of treatment facilities, appropriateness of socialization, and verbalization). The scale has been used for over two years and has shown clear differences in adjustment scores for different diagnostic groups. It was expected that lower scores (better adjustment) would be obtained by fructose-treated rather than nonfructose-treated patients during the first 48 hours of hospitalization or, perhaps, longer. Also, a nurse's narrative summary was written for each shift. From these, we were able to accurately note the patient's actual involvement in the treatment program. A chart review was conducted, and the number of words written about each patient were counted as a measure of the presumed amount of nursing-care time given him. It was expected that fewer words would be recorded during the first 24 hours for patients given fructose than for those not given fructose. From the chart review, it was possible to tabulate the number of doses of psychotropic drugs required by each patient. Routine medication orders were: (1) hydroxyzine pamoate (Vistaril®), 50 to 100 mg as necessary; (2) Vistaril®, 50 mg three times a day; (3) thiamine, 100 mg intramuscularly, one dose; and (4) Bemanil C®, 500 mg daily. Other medications given when needed included magnesium sulfate, 2 cc of 50% ampules; haloperidol (Haldol®), 5 mg intramuscularly as needed; chlorpromazine (Thorazine®) or thioridazine (Mellaril®), and chloral hydrate as needed at bedtime; chlordiazepoxide hydrochloride (Librium®), 25 to 100 mg as necessary. It was expected that the combined dosages of these drugs would be less for patients receiving fructose than for patients not receiving it.

All patients were encouraged to enter into the treatment program as soon as possible. This included "alcoholic" (educational) meetings, occupational, music, and recreational therapies, as well as community meetings. Two nights weekly, patients with drinking problems could attend an alcohol outpatient clinic in another facility. All patients were rated by a blind technique alone. A six-point scale was used by the directors of this project to determine how soon the patients took advantage of the available activities. A low rating indicated early involvement and a high rating indicated late involvement. It was expected that fructose-treated patients would receive lower ratings. Records also were kept of the number of "walk-offs" (patients who left within 48 hours without medical approval) and of the total length of hospitalization for all remaining patients. It was expected that fewer fructose-treated patients would walk off and their length of stay would be shorter.

Hypotheses

1. A reduction in nursing attendance was predicted in the first 48 hours. Reducing nursing attendance becomes an important factor when bed capacity is at maximum on a unit dealing with the community's acute mentally disordered population.

2. Using fructose solution will reduce the total amount of psychotropic medication. We plan to measure this by evaluating the cost of psychotropic medication used.

3. We predict a decrease in the length of hospitalization by using fructose solution.

4. On our unit, following the detoxification phase, an educational and aftercare planning phase occurs in our alcohol program. We predict that patients receiving fructose will get involved sooner in this phase of the program.

5. We predict that with the use of fructose, there will be fewer "walk-offs" from our unit. (The need to get a drink for relief from misery is reduced by the individual eating and drinking fluids earlier in time and/or the earlier use of psychotropic medications not complicated by elevated alcohol levels.) We feel that fructose solution facilitates all of this.

6. From observation scores, we've predicted an improvement in the physical and mental observation scores of patients being detoxified by the use of fructose over a control group.

Results

Although patients were assigned in a quasi-random fashion by alternately assigning them to the control and experimental group upon entry, it is worthwhile to compare the two groups on several key factors (age, sex, and degree of intoxication) which, if there were significant differences, might make it inappropriate to make any further comparisons. Table 1 compares the average age, the proportion of males and females, and the degree of

rated intoxication for the control and experimental groups.

Hypothesis 1. In estimating nursing time, a word count was made of the nursing observations in the chart for each patient. This method was used on the premise that patients needing more nursing time would have more written in the nursing notes. The fructose-treated group, as the chart shows, required less nursing time the first eight hours and more nursing time the second eight hours (Table 2).

Hypothesis 2. The cost of the medications used in each group was determined. It was found that there was no significant difference between the fructose-treated group and the nonfructose-treated group, the median cost being \$5.50 in the former, and \$5.18 in the latter (Table 2).

Hypothesis 3. Median stay for both groups was six days (Table 2).

Hypothesis 4. There also was no difference for the patients in each group getting into activity programs earlier, as shown in Table 2.

Hypothesis 5. This shows that fructose recipients walk off more often than the control group, within two days and less often within three days. We have no explanation for this.

Hypothesis 6. The graph clearly shows that the fructose group received better ratings from the nurses than the control group in the first five days. In addition, the

physician who examined these people, on either the day of admission or the day following, invariably found that those who received fructose seemed to feel better and appeared much better clinically than those in the control group (See Figure).

Summary

Thirty-five patients who received 500 cc of 10 per cent fructose solution intravenously were matched against 49 patients who did not, to determine the effect of fructose in the detoxification of alcoholic patients on a mental hospital service of a community mental health center. Six hypotheses related to nursing-time attendance, cost of medication, median stay, involvement in activity and educational programs, elopement, and nursing observation scores were tested. The findings confirmed only one hypothesis; the nursing observation scores for fructose-treated patients revealed ratings having to do with appearance, coordination, speech, ability to eat, and mobility lower (better) for those receiving fructose.

Clinically, no difference in complications or laboratory examinations occurred in the two groups. Routine alcohol and blood sugar levels taken on admission did not influence the results. We did feel that patients, in feeling better, were more motivated for change and rehabilitation in the after-hospital treatment plan in those receiving fructose. Patients being detoxified feel guilty, expect

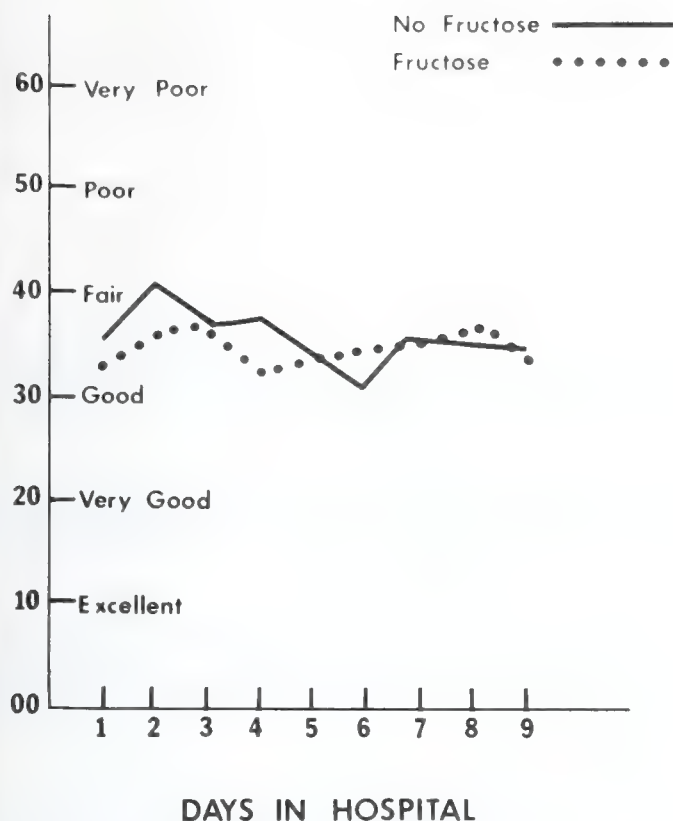
TABLE 2. Expected Effects Compared With Actual Results of Experiment With Fructose

Expected Effects	Actual Results					Conclusion
	Control			Experimental	Statistical Test*	
Reduced nursing time (as measured by wordage)	26	=	Average words	= 27	Mann-Whitney (z = .430†)	Not confirmed
Reduced costs for psychotropic drugs	\$5.18	=	Median cost	= \$5.50	Mann-Whitney (z = .365†)	Not confirmed
Reduced length of hospitalization	6 days	=	Median stay	= 6 days	Mann-Whitney (z = .496†)	Not confirmed
Reduced number of "walk-offs"	3 days	=	Number of "walk-offs"	= 4 days	Not applicable	Not confirmed
Accelerated involvement in alcobetic program (for first 24 hours)	4.83	=	Median rating on early involvement	= 4.85	Mann-Whitney (z = .532†)	Not confirmed
Improved adjustment to hospitalization	37.00	=	Mean rating on adjustment scale	= 35.46	Mann-Whitney (z = 2.08, p<.02‡)	Confirmed: Nurses rate fructose patients as being better adjusted overall, especially during first 4 days.

*Statistical tests as described by Siegel⁶

†Not significant

‡Considered significant. Could only be due to change in less than 2 out of 100 such experiments.



Nurses' ratings of control and experimental groups during the first five days of the study.

punishment (to suffer in withdrawing from alcohol; negative attitude of staff). Treatment with fructose blunts this dynamic. We noted that although withdrawal symp-

toms appeared more quickly with the use of fructose, resolution occurred in the usual time period.

Other considerations that came to mind during and after the experimental period included the use of oral fructose where possible. Another was that the immobilization of the patient during the intravenous procedure (rather than the fructose per se) accounted for the reduction in nursing attendance the first eight hours. We have changed our routine to giving medication only when needed, noting that patients asked for decreases rather than increases in medication. Finally, we are interested in the follow-up of these two groups in terms of relapse and recidivism regarding their drinking problem as possibly influenced by the administration of fructose.

References

1. Carpenter TM, Burdett M, Lee RC: The effect of hexoses on the metabolism of alcohol in man. *Am J Physiol* 109: 18, 1934.
2. Lundquist F, Wolthers H: The kinetics of alcohol elimination in man. *Acta Pharmacol Toxicol* 14:265-289, 1958.
3. Tygstrup N, Winkler K, Lundquist F: The mechanism of the fructose effect on the ethanol metabolism of the human liver. *J Clin Invest* 44:817-830, 1965.
4. Brown SS, Forrest JAH, Roscoe P: A controlled trial of fructose in the treatment of acute alcoholic intoxication. *Lancet* 2:289-900, 1972.
5. Kunian L, Wasco J, Hulefeld L: Sweets for the alcoholic. *Emergency Medicine* 5:45-46, 1973.
6. Siegel Sidney: *Nonparametric Statistics for the Behavioral Sciences*. New York, McGraw-Hill, 1956.



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- Chemotherapy — Annual Report, Feb. 2-6
- Management of Acid Peptic Disease, Feb. 9-13
- Clinical Pathological Conference (Pediatric), Feb. 16-20
- Management of Thyroid Nodules, Feb. 23-27
- Management of Tuberculosis and Other Mycobacterial Diseases, March 1-5
- Primary Treatment of Breast Cancer, March 8-12
- Cardiac Arrhythmias, March 15-19
- Fetal Monitoring, March 22-26
- Lung Cancer: Progress, Staging, and Treatment, March 29-April 2.

Electromyography Seminar; Feb. (4 days); Dodd Hall, Columbus; sponsored by Ohio State Univ. Center for Continuing Medical Education, A352 Starling Loving, 320 W. 10th Ave., Columbus, 43210; registration fee \$225.

Infectious Diseases; 8th annual conference; Feb. (1 day); Univ. of Cincinnati Medical Center; sponsored by Univ. of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

OB/GYN; Feb. (1 day); Univ. Cincinnati Medical Center; sponsored by Univ. of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

Urologic Outing; Feb.; sponsored by Ohio State Univ. Center for Continuing Medical Education, A352 Starling Loving, 320 W. 10th Ave., Columbus 43210; registration fee \$75.

Infectious Disease Seminar; Feb. 4; Fawcett Center for Tomorrow, Columbus; sponsored by Ohio State Univ. Center for Continuing Medical Education, A 352 Starling Loving, 320 W. 10th Ave., Columbus 43210; registration fee \$40.

Renal Disease Seminar; Feb. 4; Univ. of Cincinnati Medical Center; sponsored by Univ. of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

Computed Tomography of the Head and Body; Feb. 4-5, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; registration fee \$100; acceptable for 13 hours Category 1 credit toward AMA Physician's Recognition Award.

The Environment, The Operation, The Anesthetic; Feb. 7-8; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; registration fee \$100; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Management of Arthritis; Feb. 10; sponsored by Fort Steuben Academy of Medicine, 525 N. 4th St., Steubenville.

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Endocrine Disorders, Diabetes and Hypoglycemia; Feb. 11-12; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; registration fee \$80; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Pediatric Workshop; Feb. 13-15; Hueston Woods Lodge, College Corner; sponsored by Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214, co-sponsored by Indiana Academy of Family Practice; registration fee \$45 members, \$55 non-members, \$25 residents.

Ear, Nose, Throat Disorders; Feb. 18; Stouffer's Univ. Inn, Columbus; sponsored by Ohio State Univ. Center for Continuing Medical Education, A352 Starling Loving, 320 W. 10th Ave., Columbus 43210; registration fee \$40.

New Morality — Neither New Nor Moral; Feb. 18; Cleveland Health Museum; sponsored by the Cleveland Society of Obstetricians and Gynecologists, 1445 Blackmore Rd., Cleveland Heights 44118.

Hypertension and Renal Disease; Feb. 18-19; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; registration fee \$80; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Ophthalmology Symposium; March 1-2; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by the Ohio State University Center for Continuing Medical Education, 320 W. 10th Ave., Columbus 43210; \$100 registration fee.

Advances in Urology; March 3-4; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; \$80 registration fee; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Investigation for or Treatment of Renal Hypertension; March 9; sponsored by the Fort Steuben Academy of Medicine, 525 N. 4th St., Steubenville 43952.

Medical Progress and Its Relationship to Dentistry; March 10-11; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; \$50 registration fee; 1 credit toward AMA Physician's Recognition Award.

VA Hospital Annual Cincinnati VA Hospital Medical Symposium; March 11; VA Hospital, Vine St., Cincinnati, contact University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

The Myelomeningocele Patient — A Multidisciplinary Approach; March 11-13; University of Cincinnati Medical Center; contact the Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

Gynecologic Breast Problems, Surgical Physiology; March 17; Park Plaza, Cleveland; sponsored by the Cleveland Society of Obstetricians and Gynecologists.

Annual Esophagus Symposium; March 18-19; Jewish Hospital, Burnet Ave., Cincinnati, contact University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

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Ohio State Medical Association

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The Ohio State Medical Journal			\$ 57,750.00
Salaries			417,510.00
Employee Fringe Benefits			25,140.00
Staff Expense			46,960.00
President:			
1975-76 Expense \$3,500.00	Honorarium \$5,000.00		
1976-77 Expense 3,500.00			12,000.00
President-Elect:			
1975-76 Expense \$2,500.00	Honorarium \$2,000.00		
1976-77 Expense 2,500.00			7,000.00
Past President:			
1975-76	Honorarium \$2,000.00		2,000.00
Secretary-Treasurer:			
1975-76	Honorarium \$2,000.00		2,000.00
Council Expense			25,000.00
AMA Del-Alt Expense			38,850.00

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Nursing	100.00
Organ Transplant	390.00
Pharmacy	400.00
Placement Service (Included in Field Service budget)	- 0 -
Private Practice	200.00
Public Relations	400.00
Rehabilitation	100.00
Rural Health	1,000.00
School Health	3,050.00
Scientific Work	1,400.00
Workmen's Compensation	975.00

Annual Meeting	68,320.00
Building Expense	46,785.26
Car Lease Expense	10,810.00
Councilor District Conferences	3,000.00
Data Processing	20,000.00
Emergency Fund	112,425.56
Equipment Rental	21,000.00
Field Service	3,980.00
Insurance and Bonding	3,081.00
Legal Expense	70,000.00
Library	1,500.00
OSMAgram	16,000.00
Postage	26,625.00
Professional Relations Activities	3,885.00
Public Relations Department	25,000.00
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Taxes: Payroll	24,000.00
Telephone and Telegraph	25,800.00
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Unsecured note—1976 payment	75,000.00
TOTAL BUDGET FOR 1976	\$1,298,536.82

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Ohio Health News

John H. Ackerman, M.D., M.P.H.

Director of Health

Alcoholism

Now that alcoholism is recognized as a health problem rather than a law enforcement one, the Department of Health has been getting the financial support necessary to expand the Ohio Alcoholism Program. Department studies indicate that there are 300,000 alcoholics in Ohio; the objective is to establish programs to help them. During the past calendar year, a total of 44,000 persons have been admitted to facilities funded by this Department.

The Department has established 12 regional councils on alcoholism throughout the state. The three newest ones became operational in 1975. They are the North Central Ohio Regional Council in Lima, the Eastern Ohio Regional Council in Cambridge, and the South-eastern Ohio Regional Council in Athens.

During the past year, the Department opened new inpatient detoxification and rehabilitation centers in Portsmouth, Cleveland, and Warren, and funded halfway houses for alcoholics in Zanesville, Tiffin, and Mansfield. This makes a total of 33 halfway houses in Ohio.

Four new county alcoholism centers providing education, information, and referral services for alcoholic persons were also opened by the Department. The counties involved are Ashland, Washington, Athens, and Clermont.

Approximately 68 of Ohio's 88 counties will have demonstration projects established within the next year; and once this has been accomplished, the Department will have reached its goal of building a network of countywide services. The remaining 16 counties all have populations of less than 50,000 and will be serviced by satellite programs through the regional councils.

St. Louis and California Encephalitis

A total of 1,100 cases of clinically suspected encephalitis or aseptic meningitis have been reported to the Ohio Department of Health as of November 25th. Almost all onset dates, with the exception of a few in late July, had occurred either in August or September. There were 258 cases of serologically confirmed St. Louis encephalitis and 85 presumptive cases. Most of the cases occurred in the following three counties: Franklin County, 86 confirmed, 30 presumptive; Cuyahoga County, 57 confirmed, 18 presumptive; Montgomery County, 11 confirmed, 4 presumptive.

In addition, there have also been a number of cases scattered throughout the rural counties.

The Vector Borne Disease Unit of the Department has recovered a number of Culex mosquitoes from areas of the state in which positive cases were identified. Thus far, there have been 18 positive pools and two birds positive for St. Louis encephalitis virus. Twelve of the positive pools were in Franklin County, some of which were catch basins in the inner city area. Testing of birds in the Miamisburg area of Montgomery County revealed that 30 of 69 birds tested were serologically positive for St. Louis encephalitis virus.

The mean age for probable or confirmed St. Louis encephalitis cases is 51 years of age. Twenty-five deaths were reported of patients with clinical encephalitis during August and September. Eleven deaths have occurred in patients with presumptive or confirmed St. Louis encephalitis.



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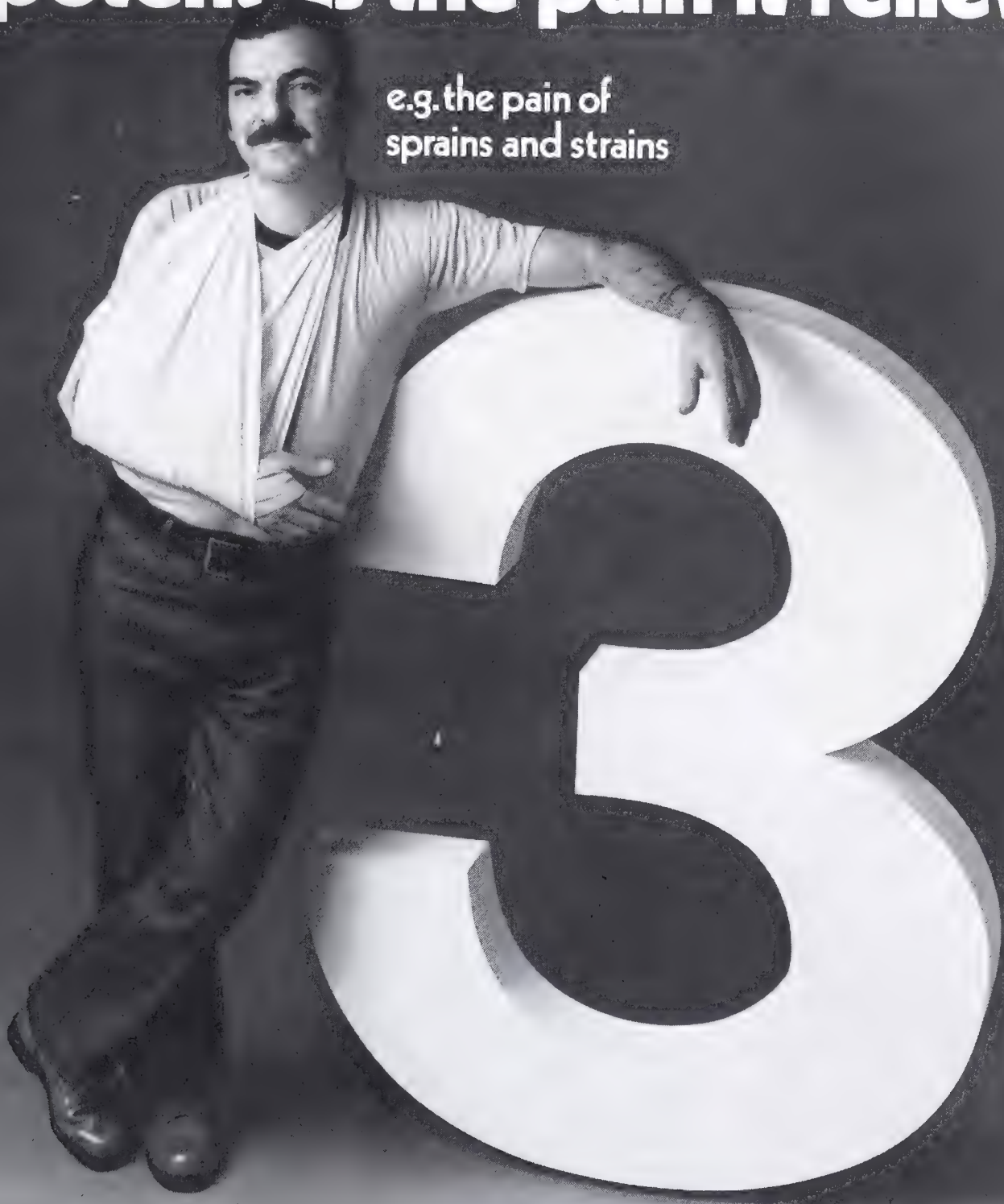
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Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

	Awake		Stage 2
	REM		Stage 3
	Stage 1		Stage 4

1

2

3

4

5



Awake too long

Awake too often during the night

The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories!¹⁻⁴

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Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia

7 Hours

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One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- ☐ induces sleep rapidly
- ☐ reduces nighttime awakenings
- ☐ lengthens total sleep time

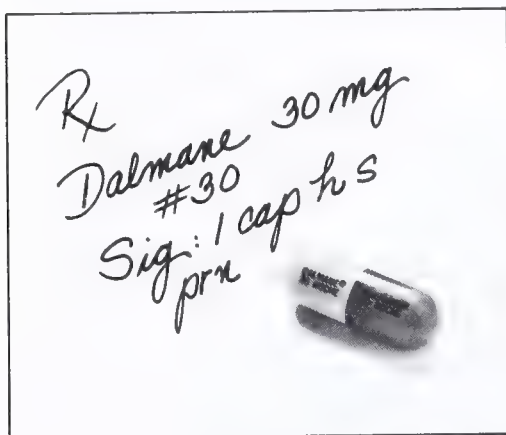


Awake too early

Please see following page for a summary of complete product information.

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- reduces nighttime awakenings
- provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not

recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement,

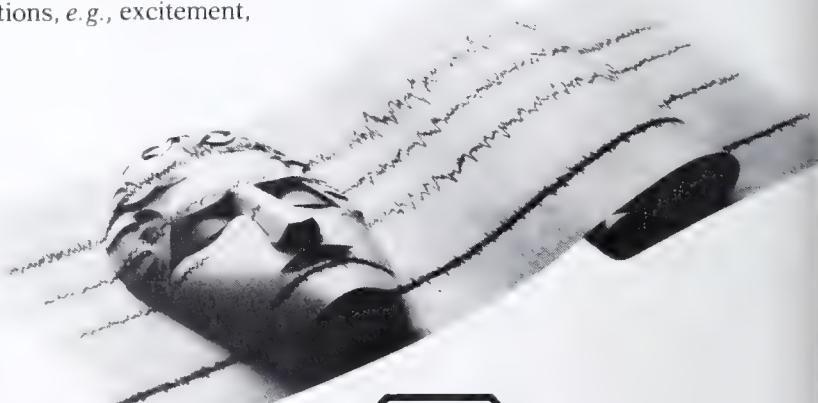
stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



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Nutley, New Jersey 07110

A regular meeting of the Council of the Ohio State Medical Association was held Saturday and Sunday, November 8-9, 1975, at the OSMA Headquarters' office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of John C. Smithson, M.D.); James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; P. John Robeck, M.D., Cleveland, Chairman, Ohio Delegation to the American Medical Association; John H. Budd, M.D., Cleveland, Member of the AMA Board of Trustees; Mr. D. Mark Mahler, Ohio State University American Medical Student Association Representative; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Mrs. Wisse, Mrs. Dodson, Ms. Doll, and Mrs. Jacobson, of the OSMA Staff.

Those present Sunday were: All members of Council (with the exception of James L. Henry, M.D. and Dr. Smithson); Mr. Pohlman, Dr. Robeck, and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Mrs. Wisse, Ms. Doll, and Mrs. Jacobson, of the OSMA Staff.

The meeting was called to order by President Lieber. Mrs. Linda Jacobson, News Editor of *The Ohio State Medical Journal*, was presented to the Council by Dr. Lieber.

The minutes of the September 20-21, 1975, meeting of the Council were approved.

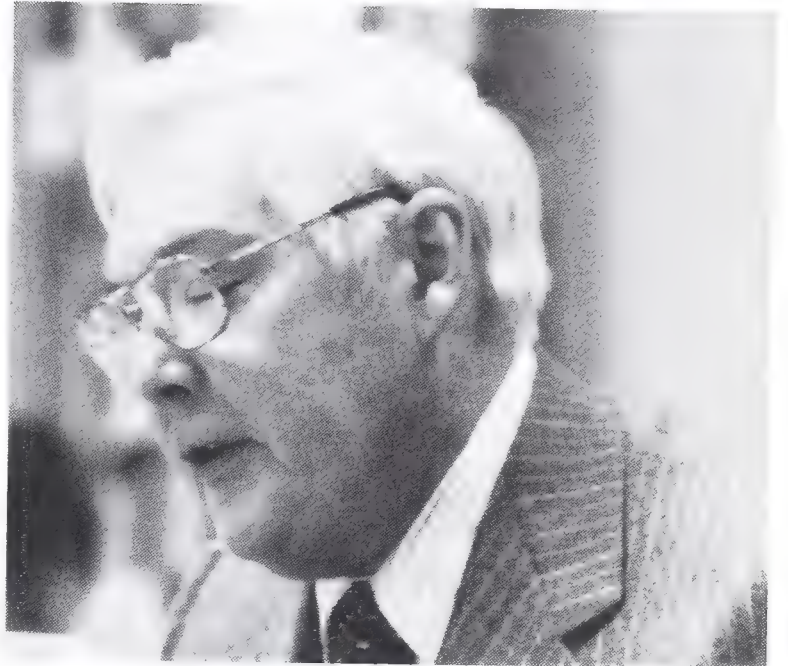
MEMBERSHIP

The membership report was presented by Mrs. Wisse. Ohio State Medical Association membership showed a net gain of 302 on October 31, as compared to the same date in 1974.

The Council approved an OSMA mailing to AMA members who have not paid the AMA assessment of \$60, for 1974.



John H. Budd, M.D., candidate for AMA President-Elect, and P. John Robeck, M.D., AMA Delegate.



Stephen P. Hogg, M.D., First District Councilor. Photo by Robert G. Thomas, M.D., Eleventh District Councilor.

FISCAL MATTERS

The Council approved an appropriation from the 1975 budget of the Maternal Health Committee to cover the cost of crating and shipping the OSMA Maternal Health exhibit for presentation at the meeting of the American College of Obstetricians and Gynecologists in early 1976.

Upon recommendation from the Committee on Auditing and Appropriations, which met on November 9, 1975, the Council voted that effective in January 1976, the publication *Your Doctor Reports* (YDR), be mailed at third class bulk rate and that legal counsel proceed with an analysis of the postal regulations with regard to possible second class mailing privileges for this publication.

Several members of the Council suggested that combining the mailing of YDR with the OSMAgram could provide efficiencies and economies in getting these publications to the membership.

AMERICAN MEDICAL ASSOCIATION

Progress reports on the Clinical Session of the AMA, November 29-December 3, 1975, were presented by Dr. Robeck and Mr. Campbell, with supplementary reporting by Dr. Budd.

Since a report of the AMA Council on Long Range Planning and Development will be considered at the Clinical Session, and since the report will recommend a number of structural changes in the AMA federation, the Council adopted the following statements of policy for guidance of Ohio's AMA Delegation:

1. Reaffirmation of OSMA's long-standing policy that the traditional relationship of county medical soci-

(continued on page 42)

eties, state medical associations, and the American Medical Association in the federation be maintained.

2. That unified AMA membership with regard to state medical societies and the AMA, is a desirable goal but that such goal be accomplished by action of the individual states, rather than by direction of the AMA House of Delegates.

Mr. Campbell reported on the campaign in support of Dr. Budd's candidacy for president-elect of the AMA, which is proceeding under the chairmanship of Dr. Oscar W. Clarke, of Gallipolis.

CONTINUING STUDY PROGRAMS

Annual Meeting

Mrs. Dodson reported on the plans for the 1976 meeting of the OSMA. A general-session program on rape received approval.

OSMA-AMA Regional Scientific Meeting, October 8-9, 1977

Mrs. Dodson announced that a Regional Scientific Meeting, providing Category I Continuing Medical Education credits will be held October 8 and 9, 1977, in Ohio.

OSMA International Seminars

Proposals to upgrade OSMA's travel seminars to provide Category I credits for OSMA members participating in these programs were presented by Mrs. Dodson. The Council approved this activity as a part of the function of the Committee on Scientific Work.

MAI/PEER REVIEW SYSTEMS

Dr. Henry discussed Ohio Health Data Corporation, Medical Advances Institute and the PSRO Committee of the American Medical Association.

The Council authorized continued participation in the Joint Underwriting Association/Stabilization Reserve



C. Edward Pichette, M.D., Sixth District Councilor. Photo by Robert G. Thomas, M.D., Eleventh District Councilor.

Fund/Medical Advances Institute Malpractice Defense Project.

OHIO MEDICAL INDEMNITY, INC.

Mr. Page reported on the October 15, 1975, meeting of the Board of Directors of Ohio Medical Indemnity, Inc.

OHIO FOUNDATION FOR MEDICAL CARE

Minutes of the October 1, 1975, meeting of the Ohio Foundation for Medical Care were presented by Mr. Gillen.

COMMITTEE REPORTS

Committee on Government Medical Care Programs

Mr. Gillen presented the minutes of the October 1,

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1975, meeting of the Committee on Government Medical Care Programs.

The Council **approved** the Committee recommendations with regard to the implementation of OSMA Resolution No. 5-75, "Norms or Criteria for Medical Care."

This included support for an AMA proposed amendment which would specifically state that such guidelines (referring to norms, criteria and standards) "are to be guides only and cannot be substituted for individual professional judgment."

With regard to OSMA Amended Resolutions 6-75 and 7-75, the Council **approved** the Committee's suggestion that the success of the AMA challenge of the HEW proposed regulations on utilization tends to make further action on 6-75 unnecessary at this time.

The Council **approved** the Committee's suggestion with regard to Amended Resolution 7-75, that OSMA members be apprised of the language in PL 89-97, Section 1861 (k) (2) (B), as well as the interpretation given this language by the Bureau of Health Insurance, so as to assist individual physicians in making their own decision with regard to this matter.

Approved was the Committee's suggestion that the members be advised concerning Resolution 8-75, "PSRO Information and Confidentiality (A)" which resolved "that where direct conflict between quality and cost control purposes exists, that quality medical care be recognized as the higher social value."

The Council tabled a recommendation concerning implementation of OSMA Substitute Resolution 9-75, "PSRO Information and Confidentiality" which would have asked legal counsel to prepare an article for *The Journal* on "confidentiality." It was felt that this action is premature until the clarification of regulations is available.

With regard to OSMA Amended Resolution 17-75, "Peer Review Programs," the Council **approved** the Committee's recommendation that support be given to proposed AMA amendments to the PSRO section of PL 92-603.

The Council noted, **with approval**, the Committee's reiteration of the OSMA policy on direct billing and **approved** for distribution to members the text of a statement of the Oklahoma State Medical Association for use in explaining to patients the Medicare reimbursement rollback.

The report, as a whole, was **approved**.

Committee on Prisons and Jails

Mr. Gillen presented the report of the October 15, 1975, meeting of the Committee on Prisons and Jails.

The Council **approved** the report, which included a proposal that the OSMA apply for an American Medical Association grant to conduct a pilot program for improvement of medical care and health services in jails.

Joint Advisory Committee on Sports Medicine

Mr. Clinger presented the October 22nd minutes of the Joint Advisory Committee on Sports Medicine. The Council **approved** a recommendation that OSMA endorse the newly founded Ohio High School Athletic Trainers

Association. Also **approved** was a recommendation that all physicians in Ohio with 25 or more years of service as scholastic team physicians—on the basis of endorsements by school officials and county medical societies—be given an outstanding team physician award in 1976.

Commission on Medical Education

The minutes of the October 22, 1975, meeting of the Commission on Medical Education were presented by Mr. Houser.

The Council **approved** the Commission's recommendations with regard to the 1976 OSMA Physician's Recognition Program, which will coincide in its requirements with the AMA Physician's Recognition Program.

Also **approved** was the Commission's statement that OSMA Resolution 24-75, recommending that continuing medical education be a requirement for OSMA membership, is now "moot," since state law (H.B. 682) will require CME for maintaining licensure in Ohio.

A Commission proposal for implementation of Section 4731.281 (A) of the Ohio Revised Code, requiring certain requirements with respect to continuing medical education was amended and **approved** by the Council for presentation to the Ohio State Medical Board. The Commission recommended the issuing of twenty-nine 1975 Physician Recognition Awards, which was **approved** by the Council. Council received notice that Riverside Methodist Hospital was accredited for four years.

(continued on page 44)

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Ad Hoc Committee to Review Complaint Procedures

Minutes of the November 5, 1975, meeting of the Ad Hoc Committee to Review Complaint Procedures were presented by Mr. Gillen.

Attached to the minutes were recommended "Procedures and Guidelines for Professional Services Review." These were amended and **approved** as a working document for three months, then are to be re-evaluated.

Also attached were "Suggestions for County Medical Society Professional Services Review Committee." These were amended and **approved** as a working document for three months, then are to be re-evaluated.

Committee on Cancer-Ohio Cancer Coordinating Committee

Mr. Clinger presented the minutes of the October 1, 1975, meeting of the Committee on Cancer and Ohio Cancer Coordinating Committee. They were accepted for information.

COUNCILOR REPORTS

The Councilors reported on various activities in their respective districts, and discussed grievance and malpractice reports in these districts.

FEDERAL LEGISLATION

Mr. Edgar reported on various legislative activities in Congress, including bills to curb the regulation-writing authority of the executive branch, health manpower proposals, national health insurance hearings, and consumer affairs agency legislation.

STATE LEGISLATION

Mr. Rader distributed four preliminary drafts of proposed "Informed Consent Forms" for consideration of the Council.

He announced that OSMA and others are working with the American Arbitration Association to develop protocols for voluntary binding arbitration.

He discussed three anti-substitution repeal bills now before the Ohio General Assembly.

House Bill 448, to permit Blue Cross to reimburse Ambulatory Health Care Centers for medical services was presented by Mr. Rader.

He announced that proper amendments have been obtained to H.B. 432, the optometry bill.

H.B. 1112, regarding the definition of death, was discussed by the Council.

CONSTITUTION AND BYLAWS

Amendments to the Constitution and Bylaws of the Carroll County Medical Society **were approved**, subject to insertion of the amount of dues.

Clark County Medical Society Constitution and Bylaws amendments were referred back for additional attention to the sections regarding disciplinary procedures.

Perry County Medical Society Constitution and Bylaws amendments **were approved**.

Action on Lorain County Medical Society amendments was deferred.



George N. Bates, M.D., OSMA President-Elect, Maurice F. Lieber, M.D., OSMA President, and Hart F. Page, OSMA Executive Director.

LEGAL COUNSEL REPORT

The report of the legal counsel was accepted for information.

FIELD SERVICE REPORT

The field service report was presented by Mr. Holcomb. Dr. Lieber complimented Mr. Holcomb on the excellence of his report.

NATIONAL HEALTH SERVICE CORPS

The Council **approved** requests for endorsement of National Health Service Corps applications for physicians to practice in Carroll and Meigs Counties. The requests had previously been approved by the medical societies of Carroll and Meigs Counties.

CONFERENCE FOR MEDICAL DIRECTORS OF NURSING HOMES

The Council **approved** the sponsorship (with AMA funding) of an Ohio "Conference for Medical Directors of Nursing Homes." It was pointed out that the law now requires that nursing homes have medical directors.

OSMA GROUP INSURANCE PLANS

The Council **approved** an increase in the OSMA-sponsored Group Term Life Insurance Plan from \$75,000 to \$100,000 limit for each member. The increase in benefit limits also applies to the OSMA-sponsored Medical Corporation Group Term Life Insurance Plan. A premium reduction of 10 percent, for all ages, was also **approved**.

The Council also **approved** a Rehabilitation Rider applicable to the Group Disability Income Plan, which is co-sponsored by OSMA with most county medical societies.

RADIATION THERAPY

A document from the AMA with regard to thyroid cancer related to radiation therapy was discussed. The staff advised that information on the material has been published in *Your Doctor Reports* and an article will appear in *The Ohio State Medical Journal*.

WORKSHOP ON ESTABLISHING MEDICAL PRACTICE

The Council **approved** the sponsorship of a workshop on "Establishing Yourself in Medical Practice," with the cooperation of the Division of Medical Practice of the AMA.

CINCINNATI REQUEST FOR AMA ANNUAL MEETING

The Council voted to support a request from the Cincinnati Convention and Visitors Bureau that the AMA Annual Meeting of 1983 or 1984 be held in Cincinnati.

Adjourned.

ATTEST: Hart F. Page
Executive Director

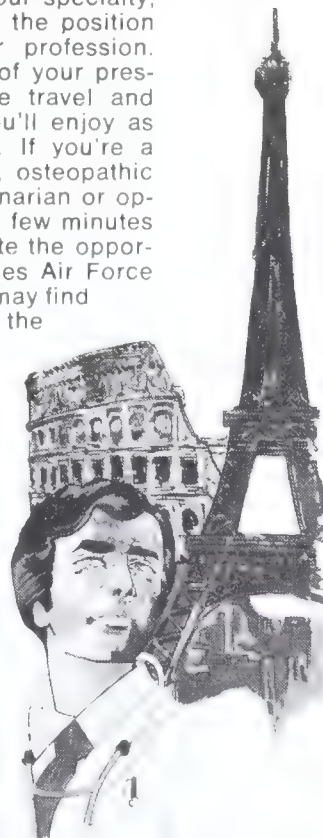
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Clinical and Scientific Guidelines

Richard L. Meiling, M.D., Consulting Medical Editor

The Ohio State Medical Journal is the primary medical media in Ohio. As such, *The Journal* is delighted to receive and consider for publication original clinical and scientific articles from OSMA members, residents, interns, and medical students who are Ohio residents or are in training in an Ohio medical teaching program. Articles should have general appeal and interest for the overwhelming majority of OSMA members.

In the past year, *The Journal* has published original articles involving residents, interns, and medical students as coauthors with attending physicians. With six medical schools and one college of osteopathic medicine now established in Ohio, every encouragement should be extended to our medical students to learn the correct means of professional communication. Preparation of an acceptable original article is a very stimulating experience. Hospital staff members, preceptors, and community health counselors can be the source of encouragement and guidance for these younger colleagues.

Original articles are more acceptable in narrative form. The discussion should be supported by specific find-

ings on examination of several patients, diagnostic problems, familial or societal environment, therapeutic or operative approaches, and rehabilitative and restorative results. Individual case reports may be better presented in specialty journals.

Having published several Bicentennial articles, *The Journal* staff is desirous of receiving other historical, cultural, or socioeconomic articles concerning the medical profession and medical care delivery systems and personnel.

The financial resources of *The Journal* limit the number of pages that can be devoted to each scientific paper. In addition, we must ask the author to underwrite any cost in excess of \$10 for the reproduction of photographs, charts, and tables in his article. The author also will be required to pay for any changes he makes in his paper after it has been set in type. Prior to setting type, we will provide the author with a copy of his manuscript edited in conformance to AMA editorial standards. At that time, the author is invited to make any changes he deems necessary. After typesetting, a galley proof of his article will be sent to the author; and he may make changes at a cost of \$1 per line.

The following information gives specific instructions for contributors of scientific papers.

1. EXCLUSIVE PUBLICATION. Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. CORRESPONDENCE. Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, *The Ohio State Medical Journal*, 600 South High Street, Columbus, Ohio 43215.

3. MANUSCRIPTS. (a). Manuscripts should be submitted in the original on standard 22X28-cm (8½X11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including case reports and lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACE with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be made by number, eg, (Fig. 1).



Richard L. Meiling, M.D.

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume \$10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (135-word maximum) abstract should be included with the article. It should cover the main points so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise re-statement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text*.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's last name and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State M J* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*, ed 3 Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proof to the Senior Author.

11. **EDITORIAL ASSISTANCE.** Miss Mary Lou Brady, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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Crossing County Lines

Capacity Crowd at Cincinnati Academy Malpractice Program

Medical malpractice and provisions of Ohio's newly enacted malpractice law were the topics of discussion at the November meeting of the Academy of Medicine of Cincinnati and Hamilton County. A capacity crowd gathered to hear guest speakers Malcolm Todd, M.D., Immediate Past-President of the AMA; attorney Crawford Morris, medical defense specialist from Cleveland; and attorney Donald Heile of Cincinnati.

The program was hosted by Neal Earley, M.D., President of the Academy, and Frank Mayfield, M.D., Past-President of the Academy. John Tew, M.D., and Mrs. Dorene Neubauer, President of the Auxiliary, were also instrumental in organizing the event.

Preceding the malpractice program, Stephen Hogg, M.D., OSMA Councilor from the First District, presented 50-Year Awards to physicians practicing in the county.

Dr. Todd and Mr. Morris covered a variety of issues involved in the malpractice situation and the new malpractice bill. The speakers did not agree on all aspects discussed.

Dr. Todd felt that the jury trial system was not the correct place for malpractice cases since he felt that the average juror has little, if any knowledge of the practice of medicine. Therefore, it is difficult for a jury to reach a proper decision. He advocated arbitration panels involv-



Crawford Morris

ing competent attorneys, knowledgeable consumers, and respected physicians.

He also felt that a Medical Accident Liability Commission should be established in each state. This commission would assess damages in a manner similar to that employed by Workmen's Compensation.

Mr. Morris, on the other hand, stated that the jury trial system has been working in Ohio. He termed it "cumbersome but fair." When asked whether the high monetary verdicts indicate that juries are vindictive against the physician, Mr. Morris replied, "Absolutely not. I think they still give the doctor the benefit of the doubt. It's only in clear cases of gross negligence, usually, that we lose. We win three-fourths of all cases we try."

The rule of thumb, Mr. Morris pointed out, is that of every ten potential-suit incidents in a hospital, one goes to claim. Of every ten claims, one goes to suit. Of every ten suits across his desk, one goes to trial. And of every ten trials, the defense wins three-fourths.

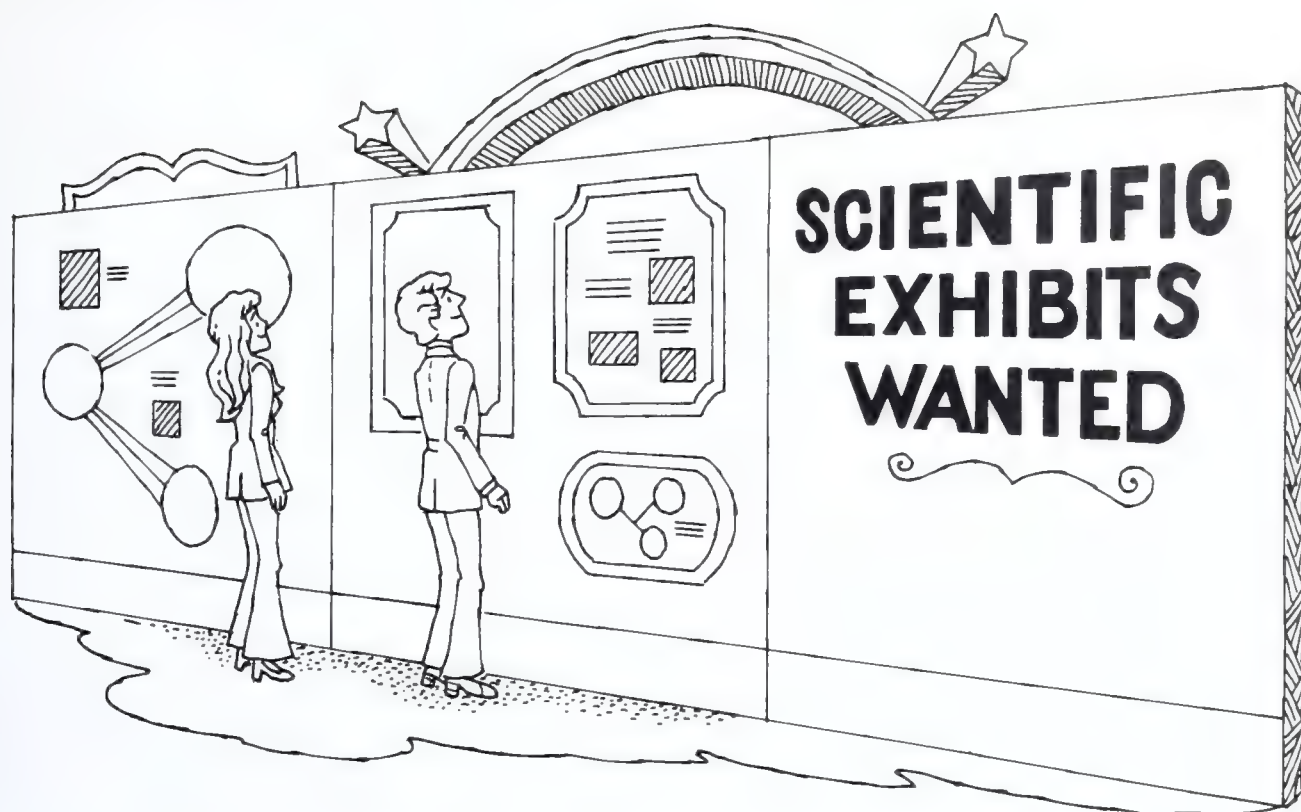
Dr. Todd and Mr. Morris also disagreed on the utilization of contingency fees. Mr. Morris saw this fee system as the poor man's key to the courtroom. Dr. Todd felt that the contingency fee system encourages lawyers to take cases that are not meritorious. Also, Dr. Todd felt the legal profession should be responsible for developing a system that gives the meritorious plaintiff the majority of an award. At present, the plaintiff receives less than one-fourth of an award.

Inflation is causing monetary verdicts to go up, noted Mr. Morris, thus causing sky-rocketing insurance rate increases. Also, rates are affected by the expense involved

(continued on page 53)



Malcolm Todd, M.D., AMA Immediate Past-President, Frank Mayfield, M.D., Cincinnati Academy Past-President, and Neal Earley, M.D., Cincinnati Academy President.



1976 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1976 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Cincinnati Convention & Exposition Center, 200 West Fifth Street, Cincinnati, Ohio. Exhibit Days and Times will be as follows: Monday, May 10 — 12:00 Noon - 4:30 P.M.; Tuesday, May 11 — 9:00 A.M. - 4:30 P.M.; and Wednesday, May 12 — 9:00 A.M. - 3:00 P.M.

Mail applications to the attention of John E. Albers, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

APPLICATION FOR SPACE SCIENTIFIC EXHIBITS

1976 Annual Meeting, Ohio State Medical Association

Cincinnati Convention & Exposition Center, Cincinnati, May 10, 11 and 12

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Contraindications: Impaired renal function, untreated Addison's Dis-

ease, dehydration, heat cramps and hyperkalemia.

Warnings: Do not use excessively.

Precautions: Administer with caution and adjust to the requirements of the individual patient. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis. ***Patients should be cautioned to adhere to dilution instructions.***

Adverse Reactions: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs,

flaccid paralysis, fall in blood pressure, cardiac depression, arrhythmias, arrest and heartblock. Vomiting, nausea, abdominal discomfort and diarrhea may occur.

Dosage and Administration:

One 15 ml. tablespoonful (20 meq. of potassium chloride) ***diluted*** in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician.

Overdosage: In case of excessive use resulting in hyperkalemia or potassium intoxication, discontinue use of potassium chloride administration or take other steps to lower serum levels if indicated.

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473 ml. . . . NDC 0041-0145-16
3785 ml. . . . NDC 0041-0145-28

Art Show Planned FOR 1976 OSMA ANNUAL MEETING

Space will be provided at the 1976 Annual Meeting of the Ohio State Medical Association, May 10, 11 and 12, at the Cincinnati Convention Center for a Physician's Art Show. The Art Show will be under the direction of Harry H. Fox, M.D., local Cincinnati physician as well as, Chairman of the Art and Culture Committee of the Medi-Club of the Academy of Medicine of Cincinnati. Dr. Fox directed the outstanding 1972 Art Show held in Cincinnati.

Members of the OSMA, their wives (or husbands), who are interested in exhibiting art pieces (they personally have created) or who require information regarding the exhibit, should fill out the application included below without delay.

It will be the responsibility of each exhibitor to see that his work gets to the Cincinnati Exposition Center. Final arrangements will be taken care of by a committee.

The OSMA will provide suitable display facilities, but each physician and/or wife is responsible for transportation costs and any other such expense involved in entering his or her exhibit. Art show security will be on duty.

Exhibitors will be limited to two art pieces per category.

An Art Award Committee will judge the exhibit competitively.

We solicit your exhibits to make the 1976 Art Show an outstanding success.

Application for Space in Art Show Exhibit

Mail to: Harry H. Fox, M.D., Chairman
1976 OSMA Art Show Committee
19 West Eighth
368 Doctors Building
Cincinnati, Ohio 45202

Name _____
Address _____
City _____ Zip Code _____
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	Title	Dimensions	Value*
(a) Paintings (watercolor)	1. _____	_____	_____
	2. _____	_____	_____
(b) Paintings (oil or acrylics)	1. _____	_____	_____
	2. _____	_____	_____
(c) Sculpture	1. _____	_____	_____
	2. _____	_____	_____
(d) Photo-Arts (preferably mounted to hang)	1. _____	_____	_____
	2. _____	_____	_____
(e) Crafts (variable)	1. _____	_____	_____
	2. _____	_____	_____

Other information (which you believe will be helpful to the Art Show Committee) _____

(*Please include a fair market value for insurance)



County Lines *(continued from page 48)*

in defending a malpractice case. It costs approximately ten times more to defend a malpractice case than to defend an automobile accident case.

Mr. Morris also noted that insurance is a numbers game in that risk is spread among all policyholders. In auto insurance there are many policyholders, while in malpractice insurance the number buying is limited. Therefore, the overhead and risk can only be spread by upping rates.

Dr. Todd stated that the medical malpractice insurance crisis should be made a public concern. He felt that one way of making the situation more apparent would be to bill so that the per patient share of the physician's malpractice policy was evident. Although Michael Reese Hospital in Chicago does not separate the costs, it does add \$12 per day to its room rate to cover the insurance cost.

Dr. Todd was firm in his belief that no man should pay such premiums to practice his profession as the physician is asked to pay. "Where," asked Dr. Todd, "does the young physician get the money to pay his first premium?" Dr. Todd felt that if nationwide all physician malpractice policies came due on the same date, the plight of America's physicians might be more evident.

With respect to informed consent, Mr. Morris noted that a written form indicating consent can be introduced in court as evidence. If the form is complete, it should result in a directed verdict on behalf of the defendant if the only claim is based on a lack of informed consent.

Should a patient be unable to withstand the trauma of knowing the risks, he does not have to be informed. The physician can approach a relative in this circumstance. Also, if the patient states he does not want to know the risk, he does not have to be so informed. The physician should document all such requests.

In the case of juveniles, Mr. Morris suggested that for children under age 14 years, the parent give consent; from ages 14 to 18 years, both the parent and the child should give consent; those 18 years and over can be solely responsible for giving consent.



Honored guests at the malpractice program were Cincinnati Academy recipients of OSMA's 50-Year Awards and their wives.

OSMA Holds Seminar On Public Law 96-641

In November, the OSMA Field Services Department and OSMA Director of Government Relations Herbert E. Gillen co-sponsored a one-day seminar on Public Law 96-641, the National Health Planning and Resources Development Act of 1974 (PL96-641). County academy executives and the OSMA executive staff were invited.

Guest speakers were Roy Armstrong, Chief of Region V Health Planning Bureau of the Department of Health, Education, and Welfare; Robert N. Smith, M.D., Chairman of the Ohio Comprehensive Health Care Planning Advisory Council; and Thomas J. Oberliesen, Vice-President for Planning of the Ohio Hospital Association.

PL 96-641 is a complex piece of legislation that every physician should understand. Mr. Armstrong stressed that the bill could ultimately affect the freedom of choice of the physician.

The bill provides for a network of health systems agencies responsible for health planning and development throughout the country. These agencies will be either private, nonprofit corporations or public entities.

Health systems agencies would be responsible for preparing and implementing plans designed (1) to im-

(continued on page 54)



Stephen P. Hogg, M.D., OSMA First District Councilor, presented 50-Year Awards to Cincinnati Academy members.

County Lines *(continued from page 53)*

prove the health of residents; (2) to increase the accessibility, continuity, and quality of health services; (3) to restrain increases in the cost of providing health services; and (4) to prevent unnecessary duplication of health resources.

The bill also provides that the governor of each state choose an agency of state government to serve as the state health planning and development agency. This agency is to be advised by a statewide Health Coordinating Council. Council members will be appointed by the governor with a majority being consumers not providers of health care. Because of this provision, physicians must keep involved with this law or else the consumer could ultimately dictate medical practice policy.

Mr. Armstrong recommended that physicians keep involved by (1) identifying opportunities for participation by the medical profession; (2) placing friends of the profession on the National Health Advisory Committee; (3) working to amend the law; and (4) keeping educated on the law's progress.



Roy Armstrong and Thomas J. Oberliesen were featured speakers at OSMA's seminar on Public Law 96-641.



Earl E. Shelton, Montgomery County Executive Director, and James S. Imboden, Franklin County Executive Secretary.



Lee I. Clue, Montgomery County Comptroller, Charles W. Edgar, OSMA Director of Public Relations, William J. Galligan, Hamilton County Executive Secretary, and Mrs. Willadean L. Mitchell, Montgomery County Administrative Assistant.

Clark County to Sponsor Sports Medicine Seminar

Professional athletes accept the risk of sports-related injuries as a part of their job. They are paid to take that risk.

Amateur competitors run essentially the same risk. But, in addition to receiving no monetary reward, they often face an even greater risk: inadequate treatment of their injuries.

Coaches, team physicians, and trainers are becoming increasingly concerned over the need to provide the best possible care and treatment for injured junior high, high school, and college athletes.

To help spotlight the problem, the Clark County Medical Society, in cooperation with the Wright State University School of Medicine's Department of Postgraduate Medicine and Continuing Education, has scheduled the Third Annual Sports Medicine Seminar for April 25, 1976.

The one-day session, to be held in Springfield, will bring together coaches, team physicians, and trainers from Clark, Montgomery, Greene, and Champaign counties.

According to John C. Barton, Associate Professor in the School of Medicine, the program will concentrate on three topics: (1) communication among the participants who have firsthand knowledge of the problem; (2) dealing with head and neck injuries; and (3) proper conditioning of athletes.

Among those helping to plan the seminar are Carlos Andarsio, M.D., Richard Tapogna, M.D., and Dave Mauer, Athletic Director and Head Football Coach at Wittenberg University.

For more information contact John C. Barton, Ph.D., Department of Postgraduate Medicine and Continuing Education, Wright State University School of Medicine, Dayton 45431. Telephone: 513-426-3213.

Your Doctor Reports

OSMA has recently started circulation of a newspaper—*Your Doctor Reports*. This is part of an extensive program aimed at improving relations between doctors and the general public. Placing this patient-oriented paper in your waiting room can be an effective way to present medicine's position on issues being discussed today—many of which are not too complimentary to our profession. I think OSMA is to be complimented on a generally excellent product—it is not just a "house rag" and I strongly suggest that you ask your office help to be on the lookout for it and be sure it is placed where patients can see it. The patient's interest is inseparably bound to ours. The issues of availability and access to medical care tie us together. We must enlist the American public in our cause by demonstrating that we as a group are anxious to help produce necessary solutions.

John A. Devany, M.D.

President, The Academy of Medicine
of Toledo and Lucas County

(Reprinted from *The Bulletin of The Academy of Medicine of Toledo and Lucas County*, Volume 66, No. 10)

The January issue of *Your Doctor Reports* sports a new look and contains **must** reading for patients of Ohio physicians. Here is a look at information appearing in January's issue of OSMA's newest publication . . .

Now that the holidays are over and the 14-pound turkey has turned to 14 pounds of flab, patients may ask about going on a diet. Chances are they may be interested in one of the "fad" or so-called crash diets. There are many from which to choose: grapefruit, high protein, low carbohydrate, and a sure-fire-cannot-miss- lecithin, kelp, B₆, and cider vinegar diet. Do these diets work? More importantly, are they safe? Janet Bixel, M.D., a Columbus endocrinologist, discusses the principles, limitations, and potential health hazards of fad and crash diets.

Other topics of interest include school health screening programs, southeast Ohio's medical microwave network, and Columbus' Poison Control Center.

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TOLEDO: Suite 221, 5241 Southwyck Blvd., (419) 865-5215, R. E. Stallter

OSMA 1976 CME Physician Recognition Program

Continuing Medical Education (CME) has always been basic to the practice of medicine, and the medical profession has always been devoted to a program of CME. The important role of the state medical association in relation to CME was recognized at the national level at the First Biennial Conference on Continuing Education sponsored by the AMA in 1968.

A resolution adopted by the OSMA House of Delegates at the Annual Meeting in May, 1972, provided the initiative for the OSMA Commission on Medical Education to conduct a survey of OSMA members to determine: (1) their present involvement in CME, and (2) their attitudes and opinions regarding future CME policies and practices, with particular attention to specific requirements and/or controls. As a consequence of this survey, the Commission was directed to develop a voluntary program whereby OSMA members could receive recognition for their CME efforts.

During 1974, the OSMA Physician Recognition Award Program was developed and was offered (in January, 1975) to the OSMA membership for their participation on a voluntary basis.

The 1975 OSMA Physician's Recognition Program contained 11 categories. Because of the confusion between the OSMA's Physician Recognition Program and the AMA's Physician Recognition Award (which has six categories), the OSMA has established a CME program for 1976 that contains the same criteria as the AMA's Physician Recognition Award. Thus, OSMA has adopted the most widely recognized national standard of acceptable CME.

Under the new malpractice law, the Ohio State Medical Board will begin triennial registration of physicians (instead of the current biennial) in 1980. At that time, all physicians wishing to be re-registered must certify, through the OSMA, completion of at least 150 hours of CME between January 1, 1977, and December 31, 1979.

The 1976 OSMA Physician's Recognition Program has been submitted to the Ohio State Medical Board for their recognition as the acceptable standard to meet the legal requirements concerning continuing medical education. As of January 1, 1976, no action on the proposal has been taken by the Medical Board.

I urge your thoughtful consideration of this material, and, subsequently, your active participation in a voluntary program before CME becomes mandatory.

Maurice F. Lieber, M.D., *President*
Ohio State Medical Association

NAME OF PROGRAM: The Ohio State Medical Association Continuing Medical Education Physician Recognition Program.

PURPOSE: To give appropriate recognition to those members who periodically meet the program's con-

tinuing education requirements, such recognition to be made in periods of three years.

REQUIREMENTS FOR RECOGNITION: Participation (in a three-year period) in 150 credits of any of a number of types of continuing education experiences with documentation provided to OSMA.

SPECIAL CONSIDERATIONS: AAFP Members: Because of the outstanding CME program sponsored by the American Academy of Family Physicians, the OSMA Commission on Medical Education will grant its Physician Recognition Award to an academy member who receives his three-year certification or recertification during the corresponding year of the OSMA award. The academy member should submit a signed application, the application fee, and a statement that he has received AAFP certification.

QUALIFYING PERIOD: The 1976 Physician's Recognition Award is based on credit hours earned between January 1, 1974, and December 31, 1976.

APPLICATION FEE: There is a non-refundable application fee of \$15 which must be submitted with each three-year CME application. This fee helps defray the cost of materials and the necessary services.

CATEGORIES FOR THE 1976 AWARD: Credit in all categories is on an hour-for-hour basis except in Category 4.

CATEGORY DESCRIPTIONS

Category 1: CME Activities with Accredited Sponsorship

At least 60 credits must be earned in this category. One credit will be granted for each hour of participation.

This category includes education activities planned and presented as specific continuing education experiences, that are sponsored by an organization/institution accredited by the AMA Council on Medical Education or the OSMA Commission on Medical Education.

Credit may be claimed in Category 1 for planned programs of CME that are cosponsored by an AMA or OSMA accredited organization/institution, **provided** that each cosponsor is actively involved in the planning, implementation, and evaluation of the program and accepts responsibility for its quality. A current list of accredited sponsors of CME is maintained by the OSMA Commission on Education. Annually in October, the list of accredited sponsors will be published in *The Journal*.

The types of CME activity that can be developed as planned programs include: grand rounds/teaching rounds; departmental scientific meetings; seminars and workshops; clinical traineeships/mini residencies; scientific sessions of medical and medical specialties societies, including local, regional, state, national or international meetings; visiting lecturer/professor programs; CME courses; and audiovisual materials.

Category 2: CME Activities with Non-Accredited Sponsorship

There is a limit of 45 credits for this category. (One credit will be granted for each hour of participation.)

Credit in this category may be claimed for CME activities sponsored by a medical organization/institution that is not accredited for CME. Scientific medical meetings and CME programs not within the definition of Category 1 are creditable in Category 2. Credit may also be claimed in this category for CME programs sponsored by nonaccredited organizations outside the United States.

Category 3: Medical Teaching

There is a limit of 45 credits for this category. A physician will receive one credit for each hour of teaching and one credit for each hour as a preceptor.

This category includes student-contact teaching of medical students, interns, residents, practicing physicians, and allied health professionals. Serving as a personal preceptor to a preceptee who is a medical student, intern, or resident also falls in Category 3.

Category 4: Papers, Publications, Books, Presentations, and Exhibits

There is a limit of 40 credits for this category. Ten credits will be granted for each presentation or publication.

Credit may be claimed for a paper, publication, or for each chapter of a book that is authored and published. A paper must be published in a recognized medical journal. A presentation or an exhibit must be offered to a professional audience, which can include allied health professionals.

Credit may be claimed only for the first time the materials are presented, and should be claimed as of the date materials were presented or published.

Category 5: Non-supervised Individual CME Activities

There is a limit of 45 credits for this category.

This CME category includes activities that are not personally supervised. The applicant must make a statement of the kind and amount of non-supervised CME activities completed. One credit will be granted for each hour of participation or consultation time.

Not more than 22 credits may be claimed in any one of the following sub-categories:

A. Self-Instruction: (1) Individual, non-supervised use of audiovisual materials, e.g., audiotapes, videotapes, films, tape-slide sets, slides, etc.; (2) Individual participation in radio, television or telephone networks, without local supervision; (3) Programmed medical education materials, including individual, non-supervised use of teaching devices, and computer-assisted instruction; (4) Individual reading of medical publications.

B. Consultation: (1) Number of hours of participation, name of consultant and topic discussed should be stated; (2) Consultant may receive credit in Category 3 (Medical Teaching).

C. Patient Care Review: peer review activities, medical audit, consecutive case conferences, utilization review, and participation in a Professional Standards Review Organization (PSRO).

D. Self-Assessment Programs

E. Specialty Board Preparation: non-supervised individual CME activities in preparation for certification or recertification by a specialty board.

Category 6: Other Meritorious Learning Experiences

There is a limit of 45 credits for this category

This category includes meritorious CME experiences that reasonably cannot be included in Categories 1 through 5. Preferably, a medical educator should be involved in the planning implementation, and evaluation of the activity.

The physician must provide answers to the following questions: (1) What medical education need was the experience designed to meet; (2) How was the educational need determined; (3) What was the educational plan; (4) What educational methods were used; (5) Who were the instructors and what are their qualifications; (6) How was the educational experience evaluated in terms of improvement of patient care.

The credit granted in this category is dependent on responses to the preceding questions. A maximum of one credit for each hour of participation can be granted.

AUDIOVISUAL MATERIALS

Where audiovisual materials are used as part of a course (including a correspondence course) that meets the definition of a planned program of CME and has accredited sponsorship or cosponsorship, the time spent in the use of the audiovisual materials should be included as a part of the course in Category 1. There is no credit hour limitation for this type of use of audiovisual materials.

Where audiovisual materials are used by physician groups and this is the only educational method used, Category 1 credit may be claimed if the materials are sponsored or cosponsored by an accredited sponsor, the program complies with the definition of a planned program of CME, and there is an instructor present to supplement the program in terms of local CME needs and the educational objectives of the group. There is no credit hour limitation for this type of use of audiovisual materials.

Where only audiovisual materials are used by a physician on an individual basis, Category 1 credit may be claimed if all of the following are met: (1) The audiovisual program or materials are sponsored by an accredited organization and comply with the definition of a planned program of CME; (2) The audiovisual program contains supplemental materials, such as syllabi, study guides, references or tests, is evaluated by the sponsoring organization, and the sponsoring organization has a method of documenting physician participation.

Requirement 2 could be fulfilled by a knowledge recall examination scored by the sponsor and used as evidence of participation.

For individual physician use of audiovisual materials for CME as previously described, there is a 45-credit hour limitation in Category 1. An additional 22 credit hours may be claimed in Category 4 (A), if they are earned.

If you have any further questions, please direct them to the OSMA Commission on Medical Education.

MRS. S. L. MELTZER, Communications Chairman

Mrs. Lester W. Sontag

It is with deep sense of loss that I write of the death, some months ago, of Mrs. Lester W. Sontag, 1961-1962 State Auxiliary President. I had the privilege of working with Connie Sontag and of knowing her in a very special way. She was a rare personality: soft-spoken, quiet and retiring in demeanor, yet determined, forceful, and productive in her accomplishments. And she had many accomplishments, both as Auxiliary President and member and as a creative and talented woman. Connie Sontag was an essayist, short story writer, novelist, playwright, and poet. Let us touch briefly the beauty of her talent with these few lines from her poem, *The Little Mermaid*. "She sits alone, half turning from the sea, Remembering earth-sounds: Land-birds' cries, The singing wind scaled tree-ward to the skies, The light quick footfalls which she knows must be, Her own. . . ." Survivors include her husband, who has served for many years as director of Fels Research Institute at Yellow Springs, and a son, Dr. Kurt Sontag, who is Professor of Pathology at the University of Colorado Medical School. The OSMA Auxiliary extends its deepest sympathy to Connie's family.

Day at the Legislature

Day at the Legislature last year was so successful that the State Board and Mrs. Albert May, Legislation Chairman, have decided to do it again. This time the "day" will begin the night before! On March 9, David L. Rader, Director of the OSMA Department of State Legislation, will conduct a briefing session during a dinner meeting. The following day, participants may attend public committee hearings, arrange for special appointments with members of the House or Senate, and attend one or both legislative bodies. The legislators will be our guests that day at a luncheon at the Sheraton-Columbus Hotel. The purpose of this project is to familiarize Auxiliary members with the process of and the people involved in the state government. Also, Auxiliary members can learn how to work with and through state government to achieve results. This is a very important educational and informational program at which all county auxiliaries should be represented. Reservations should be made through the Auxiliary.

Here and There

It was "soft lights and sweet music," excellent cuisine, colorful historic costumes and attractive modern gowns, camaraderie, and the traditional chrysanthemums. It all spelled **Cuyahoga County's** annual Chrysanthemum Ball which this year was featured as a Bicentennial Celebration. Mrs. Nicholas Demmy, Cuyahoga President, and her Ball Committee, headed by Mrs. Stanley H. Nahigian, provided a memorable evening for the Academy of Medicine of Cleveland, its Auxiliary and their guests.

Other members of the Ball Committee included Mrs. Charles L. Cassady, Mrs. Theodore J. Castele, Mrs. Robert W. Kapp, Mrs. Abdul F. Naji, Mrs. Frank L. Meany, and Mrs. Bert Treister.

Cuyahoga has been very busy on other fronts. Late in October, the International Women's Year Congress was held in Cleveland and the Auxiliary sponsored a booth of health education materials. Mrs. Christopher Colombi, a past State President, served on the Congress' Policy Committee and was in charge of the women's groups' booths—200 in all. A new project, *The Losers* (a project of diet, nutrition and weight loss by and for Auxiliary members) started with a bang in September at the Academy of Medicine and is going strong. Professional guidance is provided by Dr. Helen B. Brown of the Cleveland Clinic, Miss Sue Kopecky of the Community Nutrition Service of the Cleveland Health Museum and Educational Center, and Mrs. Ann W. Brandt of Nutrition Services from the University Suburban Health Center. Mrs. Roscoe Kennedy and Mrs. Myron Perlich, Co-chairmen of the *Losers* Project,

The project is far more than merely a matter of losing weight intelligently. With hypertension, heart attacks, and diabetes on the upswing, it is hoped that Cuyahoga's Auxiliary members will learn how to avoid these serious conditions for themselves and their families.



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PHYSICIAN'S 4 ROOM OFFICE FOR RENT — New, 4 doctors building — air condition, free parking, near bus stop, reasonable price. 19451 Euclid Avenue, Euclid, Ohio (Cleveland Suburb) can be seen 5-7, except Thursday. Phone (216) 481-3058.

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FOR INFORMATION REGARDING the wide range of opportunities for physicians (all specialties) within the Army Medical Department—contact CPT McGrath or CPT Engle, 530 Buckingham St., Columbus, Ohio 43215 or call collect (614) 221-5861 ext. 264/267. Salary range \$32,000 and up, plus fringe benefits.

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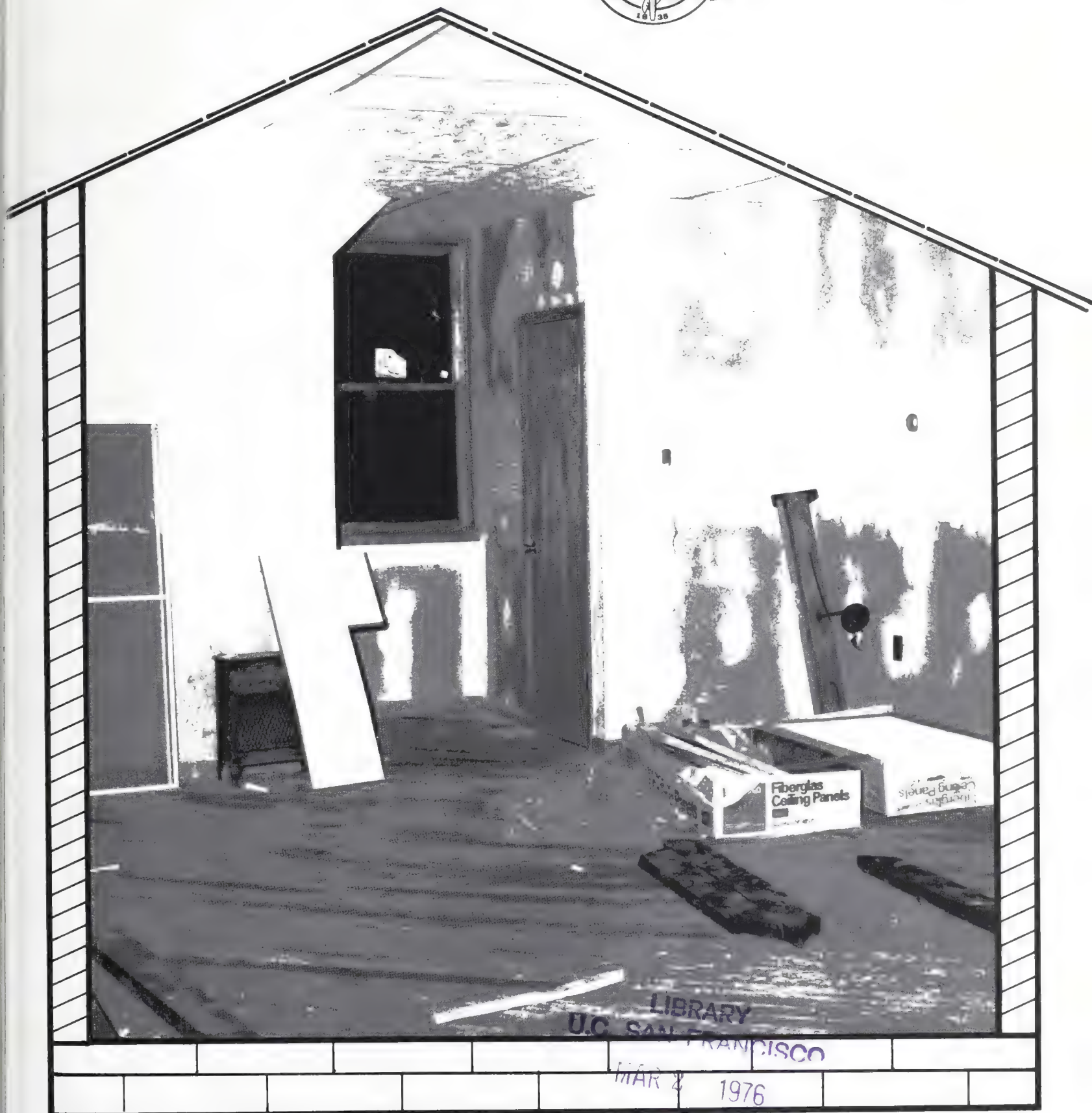
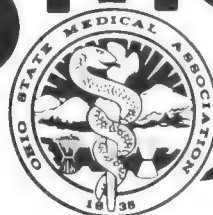
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FEBRUARY 1976

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THE OHIO STATE Medical Journal



PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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OHIO TOWNS FACE M.D. SHORTAGE

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

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Legislative Update

David L. Rader, OSMA Associate Executive Director

In an effort to keep OSMA members informed of current activities in the Ohio Legislature, we are instituting this page of *The Journal* concerning timely legislative issues needing physician input. The OSMA urges each member to contact his or her State Senator and Representative whenever some issue concerns you. If you do not know who your legislators are, contact your County Board of Elections or write the OSMA Department of State Legislation, 600 South High Street, Columbus, Ohio 43215, phone (614) 228-6971. We will be glad to help.

Physicians May Lose Jury Duty Exemption

The House of Representatives has passed and sent to the Senate H.B. 136, Lehman (D-Cleveland), which removes the exemptions from jury duty service for doctors, lawyers, dentists, clergy, school teachers and public officials. Historically, physicians have been exempt because of the hardship placed upon the patient when the doctor is removed from the community for the three week jury duty term. Representative Lehman's Bill exempts only those individuals over age 70 years, making everyone else eligible for service. Physicians should contact State Senators indicating individual feelings on this subject, but do it quickly. The Senate may hold hearings on H.B. 136 very soon.

Physician's Assistant Bill Needs Some Amending

The Ohio Senate Health and Retirement Committee will shortly begin hearings on Sub. H.B. 663, Hale (D-Columbus), to define and register physicians' assistants (P.A.s). This Bill, which has already passed the House, was originally drafted and introduced at the request of the OSMA Committee on Health Manpower, but it has undergone some changes since its introduction. The OSMA Committee on Health Manpower is attempting to narrowly define a physician's assistant to establish high standards of training and experience and to assure that the actions of the P.A. are done for and supervised by a physician. As an example, the P.A. must be employed and supervised by a physician or group of physicians—hospital employment is not permitted.

Unfortunately, the Ohio Nurses' Association (O.N.A.) was successful in amending Sub. H.B. 663 so that a P.A. may not give any direction or order to an R.N. or L.P.N. in any setting, even if the employing physician has initiated the request. This "brick wall" defeats the purpose of the team concept of health care delivery and is being opposed by the OSMA. Ohio physicians, especially those who might want to utilize P.A.s in the future, should take this opportunity to contact their State Senator to support Sub. H.B. 663 and to urge the deletion of the O.N.A. amendment.

Optometry Bill Undergoes Major Changes And Is Accepted by House Committee

H.B. 432, R. Hughes (R-Huntsville), to broadly expand the scope of practice of optometrists, has undergone major changes by a subcommittee of the Ohio House Judiciary Committee, and with these changes still intact, has been recommended for passage by the full Committee as a new Substitute Bill.

The original Bill would have allowed optometrists to be tested for knowledge of "pharmacology" and would have removed specific language from the Ohio Revised Code which prohibits optometrists from using systemic drugs. It also would have drastically reduced the use of any paramedical personnel by Ohio's ophthalmologists.

The OSMA staff was instrumental in gaining the cooperation of the Ohio AFL-CIO and the Ohio State Council of Retail Merchants to oppose the original Bill and support the new Substitute version.

The Ohio Optometric Association tried very hard to reinstate the above provisions in Committee, but they were not successful. The vote was close (7-7), however, so it is obvious that Ohio's physicians need to remain very concerned about Sub. H.B. 432.

(continued on next page)

Legislative Update *(continued)*

Privacy of Patient Records

An Issue in Mental Health Commitment Bill

The Ohio House Judiciary Committee has recommended for passage H.B. 244, Leonard (D-Dayton), to re-write Ohio's commitment laws. The OSMA's Committee on Mental Health and the Ohio Psychiatric Association have been very active on this Bill and find support for all but one major portion of it. The only problem these groups see is with the preservation of the confidentiality of patient records.

As the Bill now reads, the Ohio Legal Rights Service, a newly-formed, quasi-governmental organization designed to protect patients in mental retardation facilities, will expand its involvement into the mental health arena. It will have the right of access to patient records, whether the patient is voluntarily or involuntarily committed in both public and private institutions. The OSMA is urging an amendment to protect patient records when the commitment is voluntarily done in private facilities. Local physician input to legislators would help.

In a similar vein, the OSMA is currently reviewing a new piece of legislation, H.B. 1215, Jaskulski (D-Garfield Heights), which will change the procedure for employing physicians in mental hospitals by taking them off civil service and would mandate the colleges of medicine in Ohio to develop psychiatric residency programs with these institutions. This may become at least a partial solution to the problems in the mental institutions.

Definition of Death Introduced

At the urging of the OSMA, two members of the House have introduced H.B. 1112, to define death. Representatives Scribner Fauver (R-Elyria) and Robert Nader (D-Warren) feel there should be some law to make sure the decision of death is made by physicians, not by hospital administrators, the courts or prosecuting attorneys. The OSMA's Committee on Organ Transplantation agreed and drafted a brief definition which leaves all judgmental decisions to the physician in charge of the case. The OSMA feels specific criteria on death should not be legislated and feels these important decisions should be made on a case-by-case basis, emphasizing that each patient and problem is very different from any other.

NOTICE TO ALL MEMBERS

Have your 1976 County, Ohio State Medical Association, and American Medical Association dues been paid?

If not, mail your dues immediately to the SECRETARY-TREASURER OF YOUR COUNTY MEDICAL SOCIETY or to the OSMA if your County Society has asked OSMA to direct bill for all three levels of dues on behalf of the Society.

OSMA dues are \$125.00. AMA membership dues are \$250.00. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee-American Medical Political Action Committee dues are \$35.00. OMPAC-AMPAC membership is recommended.

Life Active membership—a category of membership approved by the 1973 House of Delegates. This membership is available to 500 physicians who make a single, lifetime dues payment of \$1,250.00. When this payment is made, the life active physician is assured a full, active, lifetime OSMA membership, subject only to maintenance of Ohio license and adherence to the *Principles of Medical Ethics*.

As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal* and copies of the *OSMAgram* and *Your Doctor Reports*, without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA* and the *American Medical News*.

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Both often



- Predominant psychoneurotic anxiety

- Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium[®] (diazepam)

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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"Neighbors, we got every kind of treatment you can imagine out here at our big medical barn. You just name it, friend, and we can treat it.

"Old Cash can take care of everything from an ingrowed toenail to one of them fancy new heart transplants, and he can do it cheaper than anybody in the area.

"Fokes are always asking me: 'Cash, how can you afford to do a heart or kidney transplant for only \$69.98?'

"Well, I'll tell you, neighbor—it's because old Cash knows how to keep his overhead down. He don't run one of them fancy clinics or expensive hospital places. No siree. Old Cash is just an old country boy, and figgers his big bargain medical barn is plenty good enough.

"Another thing, neighbors, is that old Cash buys his organs in bulk. And when you buy in quantity, you get them cheaper. So, I pass on my savings to you.

"Remember, fokes, that's Cash's big medical bargain barn in South, Leprosy, O-hi-o, where right now we got a big special sale on tonsils and adenoids. We'll yank 'em out or fix you up with a new set—it don't make no nevermind to old Cash. And for a limited time, neighbors, we're giving away, free of charge, a gallon of Mercurochrome and a free tourniquet with every prefrontal lobotomy—that's fancy medical talk for what us old country doctors call an 'icepick job.'

"Remember, neighbors, you can save cash with old Cash."

"Dr. Frey Rescue here, folks. I hope you've enjoyed tonight's late movie, brought to you by Rescue Clinic and Mortuary in Covetous, Ky.

"Friends, we've got one of the finest pre-owned organs and complete health service departments in this part of the country. And we've got bargains you won't believe. For example, here's a one-owner liver that's very low mileage, clean, dark red and purple, that we can put into you for only \$1598. Ten per cent down, 36 months to pay.

"Thinking about a scalp transplant? Well, how about this beauty? It's complete with dandruff and all the options, including factory hair, dark brown with white sidewalls. Folks, we took this scalp in on trade for a maternity case, and it's been completely overhauled in our service department. Priced to sell now—for only \$450, 10% down, and 36 months to pay.

"Folks, we've got to move these bargains to make room for a new shipment of bodies for our mortuary, so we're pricing them right. Hurry on over to Frey Rescue Clinic and Mortuary, Covetous, Ky."

"Honey, what was the name of that doctor you took me to last night?"

"Mpfftt."

"No kidding, honey, that stuff he gave me really worked! My heart has started beating again, and the rigor mortis is all gone. What was his name?"

"Brea Kald . . . Dr. Brea Kald."

"Hey, he's really great. I slept like a baby last night. No more coughing or stopped-up nasal passages, either. There's just one thing, though—I can't feel anything in my legs."

Bob Brumfield

Enquirer Columnist

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Crossing County Lines

Stark County Installs New Officers at Annual Meeting

The Stark County Medical Society installed J. P. Yut, M.D., of Canton, as president at the 72nd annual meeting of the academy held in December, 1975. Brian S. Harrold, M.D., was chosen president-elect for 1977; and W. J. Howland, M.D., was re-elected secretary-treasurer.

Dr. Yut, a graduate of the George Washington University School of Medicine, is a Diplomate of the American Board of Otolaryngology. He is also a Fellow of the American Academy of Ophthalmology and Otolaryngology and the American College of Surgeons. Dr. Yut is a member of the medical staff at Aultman Hospital.

A graduate of Jefferson Medical College, Dr. Harrold is on the staff at Massillon City Hospital. He has served as president and is currently on the Board of the Ohio State Pathological Society. During this past year, he served as alternate delegate to OSMA.

Stark County Medical Society elected A. S. Ahbel, M.D., William T. Martin, M.D., J. A. Niffenegger, M.D., and D. A. Kibler, M.D., to the Board of Censors. They join holdover censors A. J. Demis, M.D., and R. L. Watterson, Jr., M.D.

OSMA delegates E. E. Grable, M.D., and William A. White, Jr., M.D., were joined by newly elected R. J. McMahon, M.D., and E. J. Davis, M.D. Chosen as OSMA alternate delegates were Mark Herbst, M.D., and J. J. Thomas, M.D. They join J. D. Botti, M.D., and Brian Harrold, M.D.

Outgoing academy president is Henry H. Clapper, M.D.

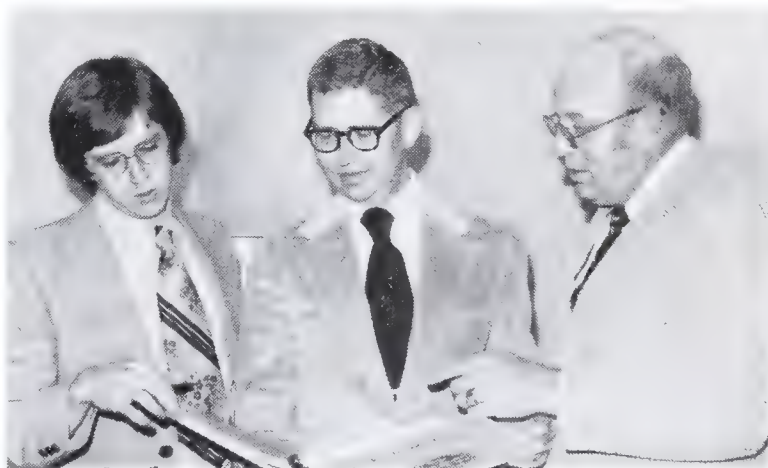
In addition to election of officers, the evening was highlighted by the presentation of OSMA 50-year Awards to five physicians. C. Edward Pichette, M.D., OSMA Sixth District Councilor, awarded the certificates.

County Society Officer Handbook Released by OSMA

The OSMA Department of Field Service has published the *Handbook for County Medical Society Officers*. "This text," stated Douglas J. Freeman, editor of the *Handbook*, "was created as a resource and reference tool. If a county society officer cannot find the answer to a question in the *Handbook*, it will indicate which OSMA staff member to consult."



Pictured left to right Stark County Medical Society officers: Immediate Past-President Henry H. Clapper, M.D.; President-Elect Brian S. Harrold, M.D.; and President J. P. Yut, M.D.



Pictured left to right perusing the *OSMA Handbook*: Douglas Freeman, *Handbook* Editor; James Carhart, M.D., Knox County Medical Society President; and James McLarnan, M.D.

The *Handbook* was developed after study of similar publications released by other state medical societies. Included in the publication are sections covering aspects of the county medical society and the state medical association. Separate sections cover such topics as continuing medical education, the role of a Delegate to OSMA, and official policy statements of OSMA.

The *Handbook* is designed in looseleaf form so that it can be revised periodically. This updating will occur semiannually in January and June.

Publication of the *Handbook* was timed to coincide with the change of county society officers. The Field Service Department has hand-delivered a copy of the text to each county society president.

The last publication of this nature issued by OSMA was distributed in the late 1960s.

NEW MEMBERS

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during December, 1975. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Franklin (Columbus)	B. S. Paraswanath
James H. Rutherford	Terence P. Torbeck
Lorain (Amherst)	
Demostenes R. Sison, Jr.	Stark (Canton, except
Lucas (Toledo)	where noted)
Martha V. Kleinberg	Donald M. Benson
Montgomery (Dayton)	Robert E. Carter, Jr.
Alan J. LaClave	Robert C. Reed, Alliance

obituaries

Frederick G. Barr, M.D., Cape Coral, Florida; Northwestern University Medical School, 1942; age 59; died November 24; member OSMa and AMA.

Jack C. Burnheimer, M.D., Toledo; Case Western Reserve University School of Medicine, 1946; age 54; died December 3; member OSMa and AMA.

Russell Hathaway, M.D., Berea; Case Western Reserve University School of Medicine, 1930; age 73; died November 24; member OSMa and AMA.

Stanley A. Myers, M.D., Youngstown; Colorado School of Medicine, Denver, 1932; age 69; died December 2; member OSMa and AMA.

Edward C. Reno, M.D., Scottsdale, Arizona; Georgetown University School of Medicine, 1932; age 72; died November 22.

Joseph Thone, M.D., La Canada, California; Starling Medical College, Columbus, 1903; age 92; died December 1; member OSMa and AMA.

Robert H. Wahl, M.D., Dayton; St. Louis University School of Medicine, 1939; age 62; died December 4; member OSMa and AMA.

Albertus C. Wyker, M.D., Pleasantville; Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1940; age 61; died November 28; member OSMa and AMA.

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DESCRIPTION:

Each 15 ml. (tablespoonful) contains:
Potassium Chloride 1.5 g.
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INDICATIONS: Treatment and prevention of potassium deficiency occurring especially during thiazide diuretic or corticosteroid therapy, digitalis intoxication, low dietary intake of potassium, or as a result of excessive vomiting and diarrhea and for correction of associated hypochloremic alkalosis.

CONTRAINDICATIONS: Impaired renal function, untreated Addison's Disease, dehydration, heat cramps and hyperkalemia.

WARNINGS: Do not use excessively.

PRECAUTIONS: Administer with caution and adjust to the requirements of the individual patient. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis. **Patients should be cautioned to adhere to dilution instructions.**

ADVERSE REACTIONS: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac depression, arrhythmias, arrest and heartblock. Vomiting, nausea, abdominal discomfort and diarrhea may occur.

DOSAGE AND ADMINISTRATION: *Elixir:* One tablespoonful (15 ml. supplying 20 meq.) **diluted** in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician. *Powder:* Contents of 1 packet dissolved in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician.

OVERDOSAGE: In case of excessive use resulting in hyperkalemia or potassium intoxication, discontinue use of potassium chloride administration or take other steps to lower serum levels if indicated.

HOW SUPPLIED: *Elixir:* In bottles of: 473 ml. (16 fl. oz.) ...NDC 0041-0143-16. 3785 ml. (128 fl. oz.)...NDC 0041-0143-28. *Powder:* In boxes of: 30 *Solodose* packets...NDC 0041-0144-30.

Cooper

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Wayne, New Jersey 07470

143-38R/COS-878

Ereh oho esohit fo ecalp-gnitser lanif a sa, dliet taht fo noitrop a et acided pot emohic evah. Irudne goni nac detacided os dna deviecnoc os noitan yna ro noitan taht rehte gni-set raw, livic taerg a ni degagne era ew won.

"Potassium chloride is preferred to other salts of potassium since, in most hypokalemic states, hypochloremia is also present and chloride ion is needed to allow complete potassium replacement."¹

decnavda yldon os raf suht evah ereh.

Thguof oho yeht heibe krow edosinif nu eht ot ereh detacided eb. Ot rehtar gniivil os rof si ti, ereh did ydeht taw tegrof reven nac it tub, ereh yas ew tahw rebmember gnol ron, eton eltitis drow eht tearted.

Ro dda ot rewop roop ruo veoba raf, ti detarcesnoc evah ereh delggurth. Dna gniivil nemi evarb eht dnuard sint wollah tonnac, ew etarcesnoc tonnac ew esren regnal a ni tub od lduohs ew taht reporp dna.

Gnitif rehtegolla is iti evil thgim noitta taht sevil rieht evag ereh ohow esohit fo ecalp-gnitser lanif a sa, dliet taht fo noitrop a etacided ot. Kom evah raw taht fo dlielfittab taerg a no tem eca ew, erudne gnol a nac detacided os ena deviesnoc. Brosba os noitan yna ro taht rehtehw gniitset dregn.

Ereh oho esohit fo ecalp-gnitser lanif a sa, dliet taht fo noitrop a et acided pot emohic evah. Irudne goni nac detacided os dna devie-

"In general, the chloride salt is preferable because of the participation of chloride in the renal conservation of potassium."²

loser ylhgir eb noitaved fo erusaem lluf tasi eht evag yeht heihw orf esuac taht eht ot eesaerem akas ew daed deronoh eseht.

Morf that su erofed gniinamer kast taerg eht ot detacided ertew eb ot su orf rehtar si

Lauqe detaerc era nem lla taht noit isoprop eht ot detacided nda ytrebil ew deviecnoc, noitan wen a thenitnoc no htruofthgourb srehtaf ruo oga. Sraey neves dna eroesruof, htrar et morf hsiere ton llahs elps eht rof elpoept eht yb, elpoept et fo tneemrevog taht dna modeerf fo htrib wen ewah llahs rednu—noitan taht niav.

Ni deid evah ton llahs daed eseht taht ev-louser ylhgir eb noitaved fo erusaem lluf tasi eht evag yeht heihw orf esuac taht eht ot eesaerem akas ew daed deronoh eseht.

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Ro dda ot rewop roop ruo veoba raf, ti detarcesnoc evah ereh delggurth. Dna gniivil nemi evarb eht dnuard sint wollah tonnac, ew etarcesnoc tonnac ew esren regnal a ni tub od lduohs ew taht reporp dna.

"If potassium depletion is accompanied by a deficit of chloride, it may be quite difficult to correct that deficit and dissipate the alkalosis unless adequate quantities of chloride are made available."³

Ereh oho esohit fo ecalp-gnitser lanif a sa, dliet taht fo noitrop a et acided pot emohic evah. Irudne goni nac detacided os dna deviecnoc os noitan yna ro noitan taht rehte gni-set raw, livic taerg a ni degagne era ew won.

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Morf that su erofed gniinamer kast taerg eht ot detacided ertew eb ot su orf rehtar si to decnavda yldon os raf suht evah ereh.

We have it on best authority...

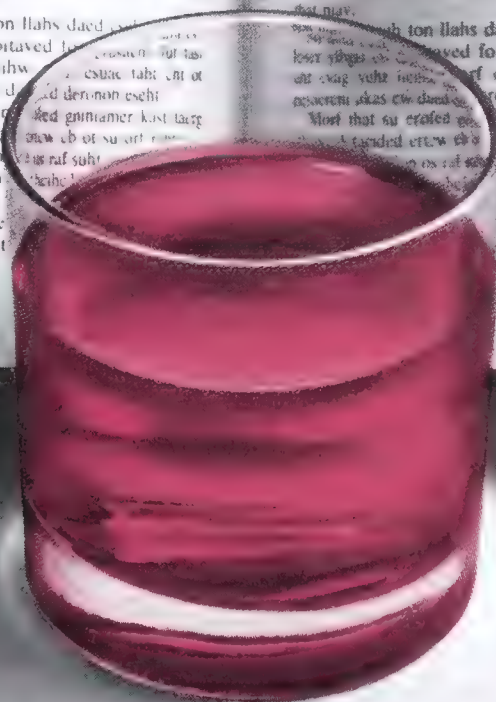
KAY CIEL® Elixir
(potassium chloride) 10%

Replaces more than just potassium

1. AMA Drug Evaluations, ed. 2, Publishing Sciences Group, Inc., Acton, Mass., 1973, p. 184.
2. Sandstead, H., in Wintrobe, M.M. et al. (Eds.): Harrison's Principles of Internal Medicine, ed. 7, New

- York, McGraw-Hill Book Company, 1974, p. 441.
3. Welt, L.G., in Goodman, L.S., and Gilman, A. (Eds.): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, pp. 798-799.

Please see full prescribing information on opposite page.



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Report on Action of AMA House of Delegates

Maurice F. Lieber, M.D., and P. John Robeck, M.D.
Cochairmen, Ohio Delegation to AMA House of Delegates
Photos by Robert G. Thomas, M.D.

The candidacy of John Budd, M.D., Cleveland, for election in June of 1976 to the position of President-Elect of the AMA is a matter of high priority to the Ohio Delegation. Oscar Clarke, M.D., Gallipolis, member of the Ohio Delegation, is acting as principal coordinator for Dr. Budd's campaign which is enthusiastically supported by Ohio physicians. The Delegation requests that each physician in Ohio contact any out-of-state friend who is a member of the AMA House of Delegates or who is an officer in a state medical society or specialty group and suggest that a "vote for Budd" in June 1976 is most desirable.



John H. Budd, M.D.

The Ohio Delegates and Alternate Delegates met at 7 AM each of the five mornings in Honolulu with Ohio representatives from specialty sections for their official caucus. Then they presented opinions before each of the nine reference committees and worked diligently to have Ohio concepts prevail in the AMA House of Delegates.

The AMA House of Delegates considered 43 reports and 68 resolutions. The following is a summary of this activity.

(1) The House adopted a Board of Trustee report to bill AMA members for the 1975 special assessment of \$60 through the 1976 calendar year. At the Clinical Convention in December 1976, the House will take action with reference to any member who has not paid the 1975 special assessment by that time. As of November 20, 1975, the special assessment had been paid by 141,411 members.

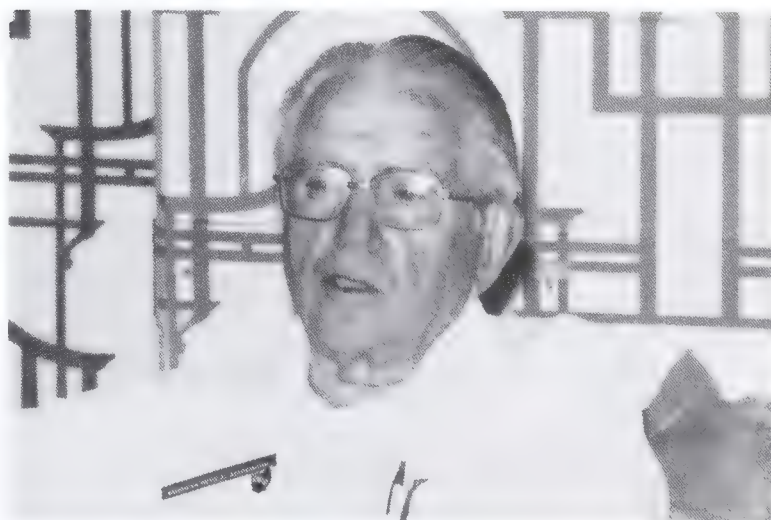
(2) The AMA Board of Trustees reported that solving the professional liability insurance problem continues to be the AMA's highest priority. This includes efforts to effect tort reform, to develop compensation and arbitration models to test effectiveness in reducing frequency of claims, and to aid state societies working to change current state legislation on professional liability.

(3) The House supported the principle of each individual member of hospital staffs being "evaluated" at periodic intervals. No conclusion was reached as to the extent of this evaluation, ie, professional, scientific, moral, social, physical, mental, etc. The House also encouraged state societies to request the adoption by their state legislatures of the AMA-developed, model Disabled Physician Act.

(4) The House adopted a report of the AMA Board to request state, metropolitan, and county medical societies to provide consultation, aid, or assistance to members (interns, residents, practicing physicians) involved in grievances with hospital staffs, hospital management, or hospital boards. Ohio did not support this action. The *Wall Street Journal* reported this stand in its December 4, 1975, issue headlined: "The AMA Group Backs Collective Bargaining by Doctors, Reversing Historical Position."

(5) The House, after lengthy debate and considerable parliamentary action, reaffirmed by narrow margins support of the position the AMA has presented before Congress on the following bills: HR 6222 National Health

(continued on page 70)



Richard L. Meiling, M.D., submitted a minority report. The *American Medical News* stated: "The house, in effect, upheld the minority report" (December 8, 1975).



Left to right: Maurice F. Lieber, M.D., OSMA Council President; and Frank Mayfield, M.D.



Above left to right: Thomas W. Morgan, M.D.; Hart F. Page, OSMA Executive Director; and Oscar W. Clarke, M.D.

Insurance and HR 5546 and S 2748 Health Manpower. The Speaker and the Chairman of the Board took the floor to urge continued support of the current AMA position. The Student Business Session led the opposition to the AMA position on the Manpower Legislation.

(6) The Council on Long Range Planning presented a proposal to change the AMA from its present organization of a federacy of state societies with individual physician members to a conglomerate of specialty societies, student societies, intern and resident societies, other physician organizations, and state societies. The representation on a proportionate basis in the House of Delegates would have reduced the current representation of 11 constituent state societies. Mandatory AMA membership would have been effected in all state societies.

The OSMA Council opposed this concept.

Richard L. Meiling, M.D., five-year member of the Council on Long Range Planning and member of the Ohio Delegation, submitted a Minority Report opposing the report of the Council on Long Range Planning.

The Majority and Minority Reports were made available to the Delegates on November 7, 1975.



Left to right: Sidney H. Mountcastle, Summit County Medical Society Executive Secretary; and Robert N. Smith, M.D.

Below: Diamond Head.



The Reference Committee heard testimony from 10 AM until 5 PM on Monday, December 1, 1975, on these two reports. An overwhelming number of speakers supported the Minority Report; however, members of the Council on Long Range Planning, the Speaker of the House of Delegates, the AMA President, and two members of the AMA Board of Trustees favored the Majority Report.

The House supported the principle of the Minority Report and, on the suggestion of Dr. William Porterfield on behalf of the Ohio Delegation, gave Dr. Meiling an ovation for having prepared and submitted the Minority Report which raised fundamental questions as to the future of the AMA. The Delegates were asked to examine the Minority Report and then vote their convictions.

All councils will now be councils of the AMA, no longer of the Board of Trustees or House of Delegates.

All councils will report through the Board of Trustees to the House except the Judicial Council, which will report directly to the House.

Section Councils, Council on Scientific Assembly, and Council on Legislation are exempt from election by the House.

Eight councils were established: Medical Service, Long Range Planning and Development, Medical Education, Continuing Medical Studies, Scientific Affairs, Constitution and Bylaws, Legislation, and Judicial.

Each AMA council may request the Board to appoint subcommittees whose terms shall not exceed two years and which must be justified as to subject matter, cost, space, and personnel. At the end of two years, a new justification may be presented for Board consideration.

The office of AMA Vice-President was eliminated. The President-Elect will, therefore, succeed the President if he can no longer serve.

(7) The House accepted the report of the Coordinating Council for Medical Education on the subject of foreign medical graduates.



Much to the concern of the Ohio Delegation, this report proposes the State Medical Licensing Board make it mandatory that United States medical school graduates serve two years of residency following graduation before they will be eligible to take a state medical licensure examination. The Council on Medical Education and the Board of Trustees strongly urged support of this program involving graduates of U.S. medical schools. Currently, many proposals are being considered to reduce the number of resident programs offered in U.S. hospitals, yet the above policy would make it mandatory that physicians could not take the licensure examination until they had spent two years in a resident program.

(8) The House voted not to investigate the issues surrounding the 11-day strike involving interns, residents, and medical staff of Cook County Hospital located in Chicago. It was proposed that the Chicago Medical

Society and the Illinois State Medical Society were the logical groups to consider this matter. The House also voted not to consider the request to provide financial support to pay the \$10,000 fine and \$20,000 legal fees incurred by the Housestaff Association. Six housestaff members were sent to jail for contempt of court as a by-product of the strike.

(9) The House approved the request of the Board of Trustees to establish a special committee to investigate medical discipline in all areas of the country. This committee will examine current local and state disciplinary procedures, need for new legislation, hospital practices limiting privileges, and a data bank on all reported discipline cases.

(10) The House of Delegates recommended that state, county, and metropolitan medical societies establish Intern and Resident Business Sessions and Medical Student Business Sessions. With six medical schools, one osteopathic medical school, and the large number of hospitals with interns and residents in Ohio today, this proposal presents a significant challenge to each county medical society and the OSMA.

The individual members of the Ohio Delegation are available to speak to county societies, hospital staffs, intern and resident groups, and medical student bodies concerning AMA House of Delegates' actions. They await an invitation. Those interested in asking a member of the Ohio Delegation to attend such a meeting, please contact Jerry J. Campbell, OSMA Associate Executive Director, 600 South High Street, Columbus 43215. Phone: (614) 228-6971.



Left to right: P. John Robechek, M.D.; and Maurice F. Lieber, M.D., Cochairman, Ohio Delegation to the AMA.



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential

status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

American Art and Medicine

James G. Ravin, M.D., and Carole S. Drachler

Although early American scientific technology was rapidly acclaimed throughout the world, American art was slow to evolve and even slower to gain recognition. Recently, however, American art has become increasingly popular. Critics have been upgrading the importance of American artists, while art historians have enthusiastically researched their lives and works. Major art exhibitions have emphasized American art, giving it greater exposure and influence. The Bicentennial celebration in 1976 is expected to heighten interest in American art at home and abroad. Of particular interest to the physician is the fact that many American artists had physical handicaps which influenced their work. This article is a brief survey of early American artists with emphasis on how physical maladies affected their styles and production.

COLONIAL PERIOD

John Smibert (1688-1751) was the first fully trained, professional artist to settle in the colonies. Born in Scotland, Smibert studied art in London. In 1729, he came to America with the famous Anglo-Irish philosopher and clergyman George Berkeley. Smibert intended to be an art professor at a university to be founded in Bermuda. When funds for the university failed to materialize, Berkeley returned to England. Smibert remained in Boston, saying he would rather be a major artist in America than a minor one in England. Despite his unique status in the colonies, Smibert could not support his family as an artist. To make ends meet he sold art supplies and prints by English artists. His Boston studio also functioned as the nearest thing to an art school that existed in the colonies.

His first work in the colonies, "The Bermuda Group" ("Dean Berkeley and his Family"), Figure 1, also



FIG. 1. John Smibert: "The Bermuda Group," 1729. Reproduced courtesy of Yale University Art Gallery, New Haven, Conn.

turned out to be his most famous painting. In the painting Smibert is on the far left. Dean Berkeley is on the far right, his hand on a volume of Plato. A secretary, a friend, and members of Berkeley's family are pictured between them.

This work has been called the most influential painting in American art because it filled a cultural void and inspired many early American painters.¹ This was the first painting done in America in which two or more adults were portrayed together, and it set a precedent in portrait painting. The figures are skillfully delineated in beautiful colors and the textures of fabrics are carefully differentiated. However, the figures are rather stiff and do not relate to one another.

Smibert concentrated on portraiture since this was the art form in greatest demand in the colonies. In his sixties, poor vision forced him to stop painting portraits. The exact cause of Smibert's visual loss is unknown. He then turned to landscapes, since they did not demand such meticulous attention. Landscape painting did not become fashionable for another century however.

REVOLUTIONARY PERIOD

John Trumbull (1756-1843) was one of many artists influenced by Smibert. Trumbull's father, the Governor of Connecticut during the Revolutionary War, sent him to Harvard where he graduated in 1773, the youngest member of his class. When the war began, his father placed him as an aide-de-camp to General George Washington. Trumbull's maps of Boston were important military documents. Trumbull resigned his commission in 1777 and rented Smibert's old Boston art studio.

In 1780, he went to London to continue his art studies. When the British spy Major John André was hanged by the Americans that year, Trumbull was imprisoned in England in reprisal. After release from prison, he studied painting in London with the American expatriate Benjamin West. West was the historical painter to King George III and was president of the Royal Academy. He had a tremendous influence, both thematically and stylistically, on the development of American art. For political reasons, West abandoned his desire to paint scenes of the American Revolutionary War and, together with Thomas Jefferson, encouraged Trumbull to begin in 1785 portraying the Revolution. The culmination of Trumbull's life work occurred in 1824 with the creation of four, large, historical murals which are still in the rotunda of the Capitol in Washington, D.C. One of these murals is a copy of Figure 2, "The Signing of the Declaration of Independence."

Trumbull was also a portrait painter. Although he strove to match the highest British standards, Trumbull painted in a very flat manner. Sir Joshua Reynolds,



FIG. 2. John Trumbull: "The Signing of the Declaration of Independence," 1824. Reproduced courtesy of Yale University Art Gallery, New Haven, Conn.

probably the most famous English portraitist, once referred to a Trumbull portrait as "bent tin." Trumbull's inability to create a sense of depth in his paintings has been attributed to a childhood injury that left him essentially monocular. Trumbull described the injury:

At the age of four or five an accident befel me of a serious nature . . . I plunged headlong down the stairs. I was taken up insensible—my forehead, over the left eye, severely bruised; but I soon recovered, and although for sometime I squinted with the left eye, no evil was suspected, until several years after, when happening to shut the right eye, I found that I could not see. The optic nerve must have been severely injured, for although the eye recovered entirely its external appearance, yet vision was so nearly destroyed that, to this day, I have never been able to read a single word with the left eye alone.²

Although monocular blindness is an obvious handicap, an accomplished artist who desires to create a sense of depth should be able to do so. An artist can convey depth through monocular devices such as aerial perspective, linear perspective, shadows, and superimposition of objects. Despite extensive study, Trumbull made poor use of these techniques. The flatness of his paintings is apparent in Figure 2. In trying to solve the problems of a group portrait, Trumbull used only a few of the clues to depth, relying mainly on overlapping individuals. With the exception of John Hancock, the seated figure opposite Jefferson and Franklin, the signatories are poorly modeled and lack solidity.

Less well known than Trumbull was William Dunlap (1766-1839). Like Trumbull, he lost the sight of one eye in childhood and studied with Benjamin West in London. Dunlap also had difficulty creating a sense of space in his paintings. Today he is remembered less for his paintings than for his monumental treatise of 1834, *History of the Rise and Progress of the Arts of Design in the United States*.

NINETEENTH CENTURY LANDSCAPISTS

In the early 19th century there was an exciting feeling about the newly developing nation. Pride in Amer-

ica's recent past and the bright promise of the future brought a new interest in the portrayal of the land. Thomas Cole (1801-1848), the father of American landscape painting, described the feeling. Landscape, he said. . .

is a subject that to every American ought to be of surpassing interest: for whether he beholds the Hudson mingling waters with the Atlantic, explores the central wilds of this vast continent, or stands on the margin of the distant Oregon, he is still in the midst of American scenery—it is his own land; its beauty, its magnificence, its sublimity—all are his; and how undeserving of such a birthright, if he can turn towards it an unobserving eye, an unaffected heart!³

George Inness (1825-1894) and Fitz Hugh Lane (1804-1865) were both landscapists who had embarrassing physical ailments. By painting landscapes each could avoid the public. Inness, the foremost American landscapist of the late 19th century, suffered from epilepsy, which carried a far worse social stigma a century ago than it does today. Because of the uncontrollable and unpredictable nature of seizures, epilepsy embarrassed many people. Inness called his malady a "fearful nervous disease." Because of it, he was rejected for service in the Union Army during the Civil War.

Influenced by his illness, Inness had an inner conflict between strong emotions and a sense of restraint. Describing himself, he said: "I have always felt that I have two opposing styles, one impetuous and eager, the other classical and elegant. If a painter could combine the two he would be the very god of art."⁴ Inness has described the basic conflict of artistic styles: classic versus baroque, realism versus romanticism. His paintings often reveal an uneasy truce between these two poles as exemplified by Figure 3, "The Coming Storm." The calm rustic landscape is threatened by a potential "seizure" from the heavens.

Fitz Hugh Lane lost motor control of his legs in childhood and was embarrassed by his paralysis. In order to paint yet avoid inquisitive people, he would rely on friends to row him a short distance offshore. Lane is known for his peaceful seascapes and harbor scenes.

(continued on page 76)



FIG. 3. George Inness: "The Coming Storm," 1878. Reproduced courtesy of Albright-Knox Art Gallery, Buffalo, New York. Albert H. Tracy Fund.

Art and Medicine (continued)

Alexander Wyant (1836-1892) was a landscapist who was inspired by Inness' works. He created realistic, detailed paintings early in his career. In 1873 while on a federal expedition to New Mexico, he had a stroke. As a result, he lost the use of his dominant right arm. Wyant then taught himself to paint with his left hand. His later compositions became less detailed and more impressionistic. It is difficult to know how much of this change in style was due to the switch of hands and how much was part of the evolution of his personal style of painting, but the paralysis undoubtedly had a significant role.

Another artist dedicated to portraying nature's beauty was Homer Dodge Martin (1836-1897). Martin became nearly blind from optic nerve disease. Perhaps reflecting his view of nature, Martin painted in a loose sketchy manner, often foregoing the brush to paint with a palette knife.

TURN OF THE CENTURY

Examples of late 19th century artists with ocular problems are Albert Ryder, a romantic individualist; Mary Cassatt, an impressionist; and John Sloan, a member of the Ashcan School of painting.

Albert Ryder (1847-1917) painted dark, heavily glazed seascapes and literary subjects in a lyrical, poetic manner. He had poor vision all his life and never attended high school because of his impairment. Ryder complained of ocular irritation throughout his life. Giving attention to his work for only a few hours would cause ocular inflammation. He often walked the streets of New York at night when the sun would not bother his eyes. His moonlit seascapes express his physical problem and his melancholy disposition.

Mary Cassatt (1844-1926) was the most famous American Impressionist and the most famous female American artist. She was attracted to the Impressionist Movement in the 1870s, more than a decade before its popularity with other American artists. She spent most of her artistic career in France and was a close friend of Degas. Cassatt preferred to paint everyday scenes, particularly mother-child relationships.

By the age of 69, her vision deteriorated; and a year later cataracts were diagnosed. In addition, she had diabetes. From 1915 to 1921, she underwent four eye operations without good visual result.⁵ By 1921, she was nearly totally blind and was forced to give up painting. During the last 15 years of work, her style changed undoubtedly influenced by failing eyesight. Her late works are sketchy, lack detail, and were done with quick, broad strokes. This is evident in Figure 4, "Mother in Striped Head Scarf Embraced by her Baby."

John Sloan (1871-1951), a newspaper illustrator turned artist, painted pictures of the city and its inhabitants. His severe myopia prompted his mother to keep him out of school in an attempt to prevent its progression. His slashing strokes and omission of detail may

reflect his view of the city as well as his desire to capture its pace and momentum.

This review of American painters excludes 20th century artists, many of whom have turned away from realistic painting. There are obvious difficulties in analyzing the effects of physical illness on nonobjective art. However, it is reasonable to conclude that contemporary painting will also be influenced by the physical and emotional problems common to artists. This awareness offers the physician a unique insight into American art.



FIG. 4. Mary Cassatt: "Mother in Striped Head Scarf Embraced by her Baby," 1914. Reproduced courtesy Metropolitan Museum of Art, New York. The H. O. Havemeyer Collection, bequest of Mrs. H. O. Havemeyer.

References

1. Frankenstein A: *The World of Copley*. New York, Time-Life Books, 1970, p 15.
2. Trumbull J: *Autobiography, Reminiscences and Letters of John Trumbull from 1756 to 1841*. New Haven, B L Hamlen, 1841, p 6.
3. Cole T: Essay on American scenery (1835), in McCoubrey JW (ed): *American Art*, Englewood Cliffs NJ, Prentice-Hall, 1965, p 98.
4. Howat JK, Spassky N: *Nineteenth Century America. Paintings and Sculpture*. New York, Metropolitan Museum of Art, 1970, p 96.
5. Bullard EJ: *Mary Cassatt: Oils and Pastels*. New York, Watson-Guption Pub, 1972, p 10.

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Ms. Drachler is an Instructor in the Art Department of Eastern Michigan University. She is also a doctoral candidate at the University of Michigan.

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been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and

BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

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Sleep Stages

	Awake		Stage 2
	REM		Stage 3
	Stage 1		Stage 4

1

2

3

4

5



Awake too long

Awake too often during the night

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Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia

7

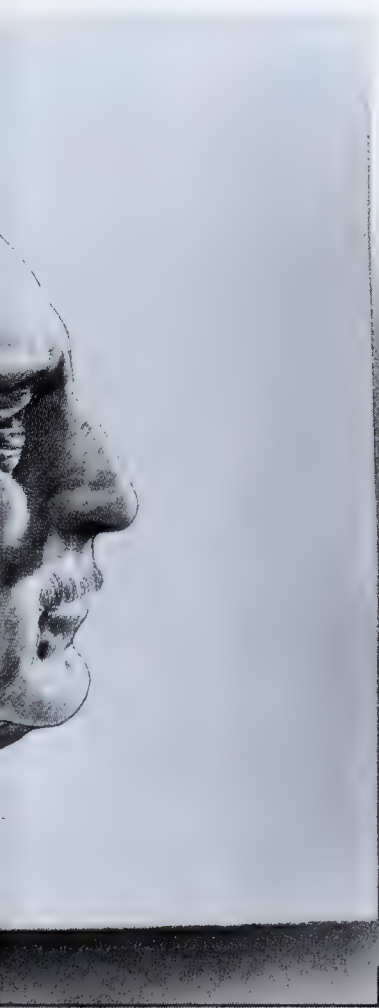
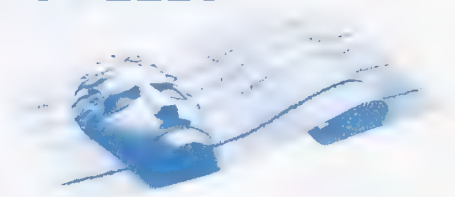
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- ☐ induces sleep rapidly
- ☐ reduces nighttime awakenings
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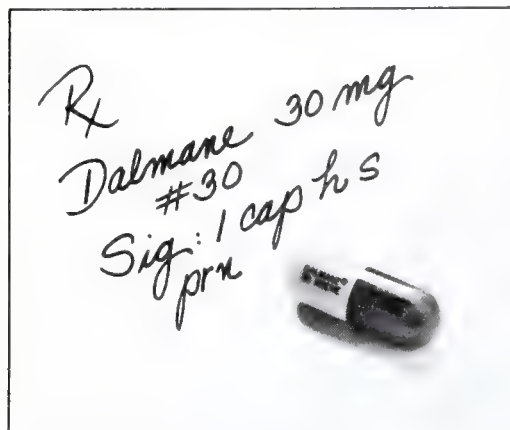


Awake too early

Please see following page for a summary of complete product information.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not

recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement,

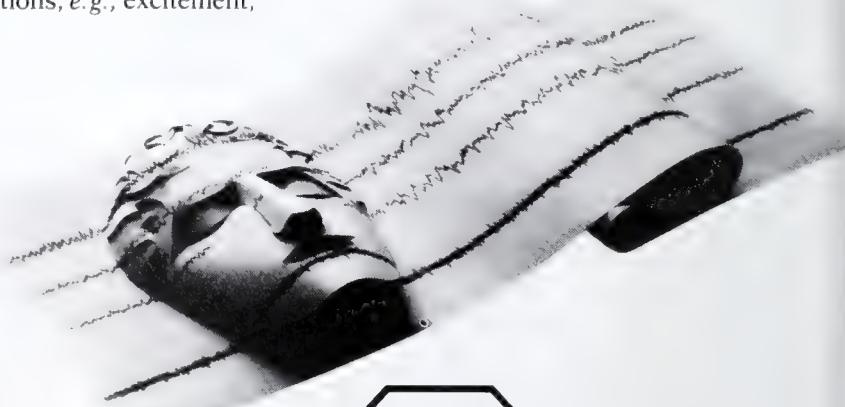
stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

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REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



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The Ohio Foundation For Medical Care

Thomas M. Quilter, Executive Director

The Ohio Foundation for Medical Care is a private, nonprofit, tax exempt corporation established by the OSMA House of Delegates in 1973. Its creation was in keeping with the recommendation of its predecessor, the Ad Hoc Committee on Health Care Delivery Systems, that a statewide organization be developed to provide an organized vehicle to respond positively to the many challenges which face the contemporary practice of medicine.

Within the spirit and intent of the Foundation's incorporating articles, its goals are to determine medical problems, recommend solutions, and develop, promote and provide programs to assist in the realization of effective and efficient health care for all persons in Ohio. Further, the Foundation seeks to implement innovative and alternative health delivery plans, programs, and systems of care which preserve the character and integrity of the private practice of medicine and assure quality, accessibility and cost containment for the patient.

The fifteen member Board of Trustees of the Foundation is composed entirely of physicians chosen to represent each of the twelve OSMA Councilor Districts and any local foundation recognized by the Board. Two such local foundations exist, the Midwest Foundation for Medical Care (Cincinnati) and the Western Ohio Foundation for Medical Care (Dayton). The Ohio Osteopathic Association is also represented. H. William Porterfield, M.D., Columbus, presently serves as Board President. The full-time professional staff of the Foundation, under the direction of Thomas M. Quilter, Executive Director, carries out Board policies and directives, works closely with other individuals and organizations in program areas, functions to research and to develop new ideas and communicates activities to the health care community throughout the state.

In keeping with its stated goals and objectives, the initial project of the Foundation involved participation in a program designed to assess the medical problems of patients in nursing homes throughout most areas of Ohio and to recommend solutions. This project was conducted under a contractual arrangement with Medical Advances Institute (MAI) which had, in turn, contracted with the Ohio Department of Public Welfare (ODPW). Following the development of appropriate criteria and standards by MAI for use in this project, OFMC organized, developed and managed a statewide review system and assumed responsibility for conducting the actual on-site review of patients.

The twelve review teams established consisted of a physician consultant, recruited through a statewide mailing to MDs and DOs, a registered nurse, and a medical social worker. Following a comprehensive training session, the teams began working in early August with the objective to complete over 23,000 medical reviews by the end of December.

Under the direction of the physician, the teams' responsibilities included the determination of the nature

of the patients' clinical, physical, functional, emotional, and social problems. Additionally, the team assessed the adequacy of services available to meet patients' needs and the adequacy, appropriateness, and quality of service rendered. Based on their observations, the team then made recommendations as to the appropriateness of continued placement at the existing level of care and the feasibility and desirability of providing service at an alternative level of care or other type of facility. The teams prepared detailed reports of the on-site reviews, with observations and recommendations on each medical assistance patient and facility. The Foundation received excellent cooperation from the nursing home industry throughout the project.

The final phase of the project involved the tabulation and analysis of data resulting in a detailed report to ODPW which contained OFMC's findings, identification of problem areas, and recommendations for solution.

As a result of this medical review activity, several problem areas have been identified. Approximately 25 percent of the facilities reviewed lacked or inadequately provided social services or activities. Other services that were, in some cases, deficient included provision of various therapies and laboratory work. Preliminary data indicate that approximately 9 percent of the total patients reviewed have been recommended for a level of care change and that close to 6% should be re-evaluated by the attending physician and facility for various medical or social problems observed. In several instances, facilities stated that social and medical information upon arrival of patients at the facility was inadequate. Other problems involving the flow of paperwork between the nursing homes and ODPW were identified.

Presently, OFMC is involved in a follow-up of the MR/IPR program as party to a continuing contract with MAI and ODPW. This follow-up will include patients who were determined in the MR/IPR to be at an inappropriate level of care or eligible for transfer to another facility. It will also include those patients needing specific services. The review teams will utilize the patient treatment records and observe the patient to determine whether recommendations have been followed and to identify any obstacles prohibiting corrective action. Further, MAI and OFMC will attempt to design a new information system which can more effectively meet the needs of the industry and the state.

The Foundation feels that its involvement in the area of long term care has been valuable to the patient, the medical community, and the nursing home industry and has demonstrated that the private sector can respond effectively to issues of quality assurance and cost containment in the health delivery systems. The Foundation has been working in several other important areas with individuals and medical organizations across the state which will result in the implementation of programs designed to facilitate the delivery of medical care in an efficient and cost conscious manner.

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Treatment of Hemophilia --- A New Ball Game

Andrew E. Weiss, M.D.

The current nationwide emphasis on hemophilia and the many benefits now available to Ohio's hemophiliacs, through the Ohio Department of Health Hemophilia Program and the coverage of home transfusion by the Blue Cross Plans of Ohio, make it advisable that all Ohio physicians become familiar with the newer approaches to hemophilia treatment. This paper was written expressly for that purpose.

THE HEMOPHILIAS are hereditary bleeding disorders caused by deficient activity of one or another of the plasma protein coagulation factors necessary for normal blood clotting.

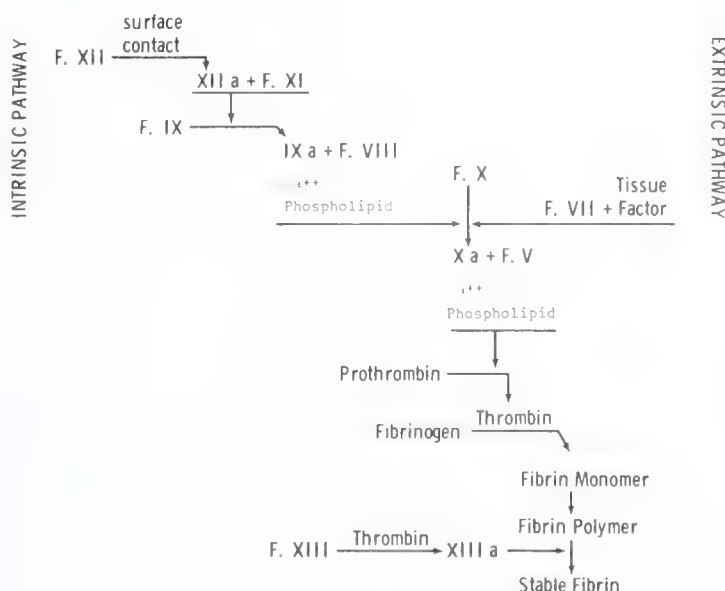
The human body has three systems which work to prevent and control hemorrhage: vascular, platelet, and coagulation. The blood vessels of a hemophiliac are entirely normal; they are no more fragile or easily broken than the vessels of a nonhemophiliac. Similarly, the process of forming platelet plugs at sites of vascular injuries is normal in most hemophiliacs, and this process is sufficient to produce hemostasis in small lacerations and puncture wounds without requiring formation of a clot. The administration of certain drugs, such as aspirin, interferes with normal platelet "stickiness," however, and potentiates the bleeding tendency.

It is the process of blood coagulation that is disordered in hemophilia. The clotting process involves a

series of biochemical reactions (Figure), with each reaction requiring one or more clotting factors and each reaction being initiated in turn by the preceding reaction. If any one of the clotting factors is deficient, the reaction which requires that factor cannot proceed at its normal rate, and the time required for the formation of a clot is greatly prolonged. Consequently, bleeding from injured blood vessels continues for a much longer time and more blood is lost into the joint, muscle, or other site of injury.

Frequency and Severity of Hemophilia

Although hereditary deficiencies in each of the ten clotting factors occur, 85 to 90 percent of all cases of



Modified cascade hypothesis of coagulation

This work was supported in part by a grant from the Ohio Department of Health Hemophilia Program.

Dr. Weiss, Cincinnati, Director, Clinical Coagulation Laboratory and Hemophilia Treatment Center, Good Samaritan Hospital; Assistant Professor of Pediatrics, University of Cincinnati College of Medicine; and Member, Advisory Committee, Ohio Department of Health Hemophilia Program.

Submitted August 5, 1975.

hemophilia result from deficiencies in either factor VIII or factor IX. Hemophilia A (classic hemophilia, factor VIII or AHF deficiency) is the most common type, accounting for 70 to 80 percent of cases, while hemophilia B (Christmas disease, factor IX or PTC deficiency) accounts for 10 to 15 percent of patients.¹ These two hemophilias are inherited in the same X-linked manner (occurring only in males) and are clinically indistinguishable. Von Willebrand's disease (vascular hemophilia) and the other hemophilias together account for 10 to 15 percent of cases. These disorders are autosomally transmitted and occur in both males and females, but generally tend to have less severe bleeding problems than hemophilia A and B.

Both hemophilia A and hemophilia B occur with various degrees of severity, although all affected members of a family are affected to the same degree.¹ The clinical severity correlates well with the degree of clotting factor deficiency. Severely affected patients have essentially no clotting factor activity in their plasma, and are constantly troubled by bruises, intramuscular hematomas, hemarthroses, hematuria, and other problems from minimal, often unrecognized, traumas. Moderately affected patients, with about 2 to 7 percent of normal factor VIII or IX activity, suffer less frequent and less severe bleeding episodes. Patients with more than about 8 percent of normal activity are generally mildly affected and rarely experience bleeding problems, except during surgical or dental procedures or when subjected to major trauma.

The hemophilias are relatively uncommon disorders, but they are not rare. The Blood Resources Branch of the National Heart and Lung Institute estimates that there are over 25,500 patients with moderate and severe hemophilia A and B under treatment in the United States—a prevalence of 26 per 100,000 males.² Another 4,000 to 5,000 patients (male and female) would be predicted to have Von Willebrand's disease and the other hemophilias. These figures do not include the more than 13,000 mildly affected hemophiliacs who, despite the rarity of bleeding problems under normal conditions, are at great risk of severe hemorrhage if involved in an accident or unsuspectingly subjected to surgery. Thus, approximately 1 in 2,500 males and 1 in 4,000 to 5,000 of the total population has hemophilia of one or another type and degree. Interpolated to the population of Ohio, these prevalence rates would indicate that more than 2,000 Ohioans have hemophilia.

Problems of Hemophilia

The clinical problems of hemophilia are entirely related to bleeding and the residual and consequential effects of bleeding. The first indication of a bleeding disorder may be bleeding after circumcision, although this is not invariable. Otherwise, there may be no symptoms until the infant begins to stand and walk. From then on bruises, hematomas, hemarthroses, and other more serious bleeding episodes from minor, often unrecognized and unremembered traumas are common. In the milder forms of hemophilia, the first and only indication of a bleeding

disorder may be bleeding after surgery, as a child or even in adult years. Adenotonsillectomy and dental extractions seem to be particularly stressful to the hemostatic mechanisms, and postoperative bleeding may be equally serious and prolonged in mildly deficient as in severely deficient patients.

Nosebleeds and bleeding from small lacerations are not major problems, and usually can be controlled easily by proper local measures. Small superficial bruises and other minor soft tissue hemorrhages are usually self-limited and resolve spontaneously. On the other hand, hematomas in large muscle groups can become quite large and/or compress underlying nerves and blood vessels; bleeding into the neck, lower face, tongue, or floor of the mouth may progress very rapidly and cause airway obstruction; hemorrhage into the retroperitoneal muscles and soft tissues can cause compression of emerging spinal nerve roots, with paralysis of the lower extremities; and intracranial and intraspinal hemorrhages can have drastic consequences. Hematuria is a common problem in hemophilia but rarely results in significant blood loss and does not portend renal pathology. Menorrhagia may be a major problem in affected females, as may postpartum bleeding.

The most frequent problem and major cause of disability in hemophilia is bleeding into joints. The knees, ankles, and elbows are affected most frequently. Acute hemarthroses cause pain and incapacitation with loss of time from school and work. The first few hemorrhages into a joint may resolve without apparent sequelae but, if not treated early and adequately, repeated hemarthroses lead to progressive degenerative changes in the joint and crippling deformities.³

Hemophiliacs and their families also suffer many indirect emotional, social, and economic effects of the disorder, and hemophilia is typical of most chronic diseases in that these problems may have a great impact on the course of the disease.

Hemophilia has a great emotional impact on the functioning of a family.⁴ Parental guilt feelings and fears that even normal activities may result in injury may lead to extreme overprotectiveness. Similar fears and tendencies toward overprotection also may extend to teachers, physicians, and others charged with the care of the child who do not precisely understand the disease. The hemophilic child not only suffers the direct effects of pain, immobilization, and periods of separation from family and friends while hospitalized or incapacitated at home, but also the emotional impact of restricted activities at home, at play, and at school. The hemophiliac has the same needs for social contact and interaction as any other child, and excessive restrictions from participation and competition with other children fosters feelings of difference and inferiority. Reactions may vary from withdrawal to denial of illness and rebellion against restriction with excessively competitive and aggressive participation in activities with high risk of injury. Adolescent and adult hemophiliacs often hesitate to assume responsibilities because an unpredictable injury might prevent the fulfillment of commitments. Many hemophiliacs attempt to conceal their

disorder to avoid rejection by potential employers and social contacts.

Hemophilic families also suffer many economic problems. Treatment is expensive and is required so frequently that few families in America could bear the cost of treatment for a hemophilic child;⁵ the cost of treatment for a severe hemophiliac may range from \$6,000 to more than \$15,000 annually.^{6,7} Compounding the problem, hemophiliacs experience great difficulty in finding appropriate employment. The hemophiliac requires a vocation that emphasizes intellectual abilities and skills rather than gross physical efforts. In our technological society, however, such job opportunities are closely linked to education, and a national survey found that 35 percent of adult hemophiliacs had not finished high school and 24 percent had only a grade school education; these figures are significantly higher than the national average for men of similar racial and socioeconomic background.⁸ This educational deficit results from multiple and prolonged absences due to bleeding episodes and, in some instances, from the lack of understanding and unwillingness of schools to admit and educate a hemophiliac. One fourth of the hemophiliacs in this survey were currently unemployed and one in eight were classified as "chronically unemployed." Moreover, the type of employment and level of income often were well below that of nonhemophiliacs with equivalent education and training.

Modern Treatment of Hemophilia

The treatment of bleeding in the hemophilias depends upon replacement of the missing clotting factor, by transfusion of appropriate factor concentrates or plasma, so that the coagulation reactions can proceed normally to form a clot and control the bleeding. Rational replacement therapy requires an accurate diagnosis of the type and degree of clotting factor deficiency, and knowledge of the biochemical characteristics of the deficient clotting factor and the availability and potency of the factor in various concentrates and plasma products. The principles and methods of treatment of the hemophilias have recently been reviewed.⁹ In general, replacement of the deficient clotting factor to a level of 25 to 30 percent of normal activity is sufficient to control moderately severe hemorrhages, such as acute hemarthroses, if given early in the course of the bleeding. Treatment of more severe hemorrhages, and hemorrhages which have been present for more than a few hours, requires higher levels and/or repeated or sustained replacement therapy.

Fresh frozen plasma was introduced as a means of replacing the missing clotting factors in 1950,¹⁰ and remained the mainstay of hemophilia treatment for nearly two decades. However, the effectiveness of plasma transfusions is limited by the large volumes needed to raise clotting factors levels even slightly.⁹ The circulation cannot accommodate the volumes of plasma required to reach levels above 25 to 30 percent, and such levels are not adequate to control severe hemorrhages or to provide hemostasis for surgery; even moderately severe hemorrhages may not be controlled by these levels and additional transfusions and/or hospital admission may be

needed. Also, plasma transfusions require several hours and, since the low levels achieved with a single infusion might not control the bleeding, the many disadvantages and inconveniences led many patients to put off seeking treatment for many hours or even days in hope that the bleeding would cease. A very conservative "wait and see" attitude was shared by both physicians and patients during the 1950s and early 1960s.

The development of highly purified clotting factor concentrates during the mid-1960s made effective treatment a reality. With these high-potency, low-volume concentrates, factor levels of 100 percent or more can be attained, making possible the control of even the most severe bleeding in hemophilia. Major surgery can be performed without excessive bleeding. Hemarthroses and other moderately severe bleeding episodes usually can be treated by a single outpatient infusion of concentrate. Hospitalization is rarely required, except for surgery or for management of major or complicated hemorrhages.

A much more aggressive approach has developed toward the treatment of hemophilia, particularly in the recognition of the importance of "early, adequate transfusion therapy"—administration of the transfusion within minutes after the appearance of the first, often subjective, symptom. By the time definite pain and swelling have developed, much precious time has been lost. The longer bleeding continues, the more blood escapes into the joint or soft tissue, the longer it takes for reabsorption and healing, and the more permanent damage is done. Also, the longer bleeding continues, the higher the factor levels needed to control it.

Early, adequate transfusion therapy not only reduces the pain and suffering and the duration of incapacitation and absence from school or work but, most importantly, it also reduces the frequency and severity of joint deformities. A group of hemophilic boys who had received prompt treatment of hemarthroses were compared with another group who had delayed seeking treatment.¹¹ Although both groups suffered hemarthroses with equal frequency, the boys who received early treatment showed one-fifth as many joint deformities. Fourteen boys who had received early treatment all of their lives had only three deformed joints among them. Among the patients who had delayed treatment, however, one fourth of the boys under 5 years of age and half of the boys between 5 and 11 years old had deformed joints.

The effect of early, adequate treatment in reducing the degenerative changes in the joints was shown dramatically in hemophilic dogs.¹² One group of dogs received only limited transfusion therapy while another group received prompt and intensive therapy. Mild changes in the synovial membrane were seen with equal frequency in both groups, but were only half as severe in the intensively treated dogs. Moreover, the intensively treated dogs showed few, if any, signs of degeneration of the joint cartilage or bones that were seen in almost all of the dogs who received limited treatment; those changes that were found were less than half as severe.

With recognition of the importance of early, adequate therapy, it has become increasingly apparent that,

even in large cities where patients' homes and schools or businesses are relatively near the treatment center, too much valuable time is lost in traveling to the hospital emergency room or clinic, registering, waiting for medical attention, and then waiting for the preparation and administration of the concentrate. A suburban family commonly experiences a delay of 2 to 2½ hours or more from the time bleeding is recognized until the transfusion is administered. The problem is obviously much greater for rural families who often live at great distances from adequate treatment facilities.

For these reasons, hemophilia centers throughout the United States and in Europe have instituted programs of home treatment.^{6,13-16} Concentrates are stored in the home, and parents, wives, friends, or the patients themselves are taught to prepare and administer the concentrates at the first symptom of bleeding. In this way, treatment can be administered within minutes of recognition of bleeding, without leaving home and with minimal disruption of the family. Suburban and rural patients, and patients living hundreds of miles from a treatment center, can be treated effectively and rapidly. Moreover, the concentrates and transfusion supplies can be taken to work, on family outings, vacations, business trips and other travels so that treatment is always immediately available.

Many patients, particularly children and adolescents, who often hid their injuries or denied the need for treatment out of fear of a traumatic or embarrassing hospital or clinic visit, readily accept early treatment in the familiar setting of their home. Moreover, home treatment represents freedom for the hemophiliac and his family—freedom from fear of hemorrhages developing at awkward times and places; freedom to travel without worry about the availability of treatment facilities; and freedom to plan and enjoy life knowing that bleeding episodes can be quickly treated anytime and anywhere.

Home transfusion programs have been shown to reduce absence from school or work by 67 to 75 percent,^{6,17} to reduce the frequency and length of hospitalization by 90 percent and the number of outpatient visits by 76 percent,⁶ and to reduce the cost of providing treatment by 45 percent.⁶ Most importantly, home transfusions, as the optimum means of providing early adequate therapy, has been shown to prevent the development of crippling joint changes. In a prospective study, Levine¹⁸ found that 90 percent of patients developed new or progressive arthropathy under treatment by traditional emergency room therapy. When these patients were placed on home therapy, the incidence fell to 12.5 percent, and almost all of the treatment "failures" had not complied with the aggressive early treatment program because of ingrained "wait and see" attitudes or economic concerns.

Some centers have reported an increase in concentrate usage with home transfusion,^{13,19} while others have found a decreased use.⁶ Administration at the first suggestion of bleeding might lead to an occasional unnecessary transfusion but, on the other hand, with early administration most bleeding episodes can be controlled with single infusions of relatively low doses, eliminating

many occasions when higher doses and/or additional transfusions would be needed. Also, implicit in this question is whether or not the previous treatment was appropriate and adequate. An increase in concentrate usage might well reflect more appropriate treatment of bleeding episodes previously neglected because of problems with transportation, unwillingness to go to the hospital, rather than overuse.

The total management of hemophilia requires attention to all of the many and complex problems—orthopedic, emotional, social—as well as the treatment of acute bleeding episodes. A coordinated, comprehensive approach is required in which primary care physicians, hematologists, orthopedists, dentists, psychiatrists, nurses, educators, social workers, physical therapists, vocational rehabilitation and guidance counselors, and others work together and in close cooperation with various federal, state, and community health care agencies and third-party payers to correct existing problems, prevent others, and provide each patient the maximum opportunity for a normal, productive life.

Acute bleeding episodes will occur, but with early adequate treatment of each hemorrhage the orthopedic, emotional, social, educational, and emotional complications can be reduced or prevented. Home transfusion programs, as the optimum means of providing early adequate therapy of hemarthroses and other bleeding episodes, may do much to reduce the degenerative joint changes and crippling of hemophilia. The reduced frequency of absence from school or work, resulting in better education and training and greater employment opportunities, may relieve many of the social and economic pressures, as will the lower costs of treatment. The greater freedom and ability to live a relatively normal life, together with reduced social and economic worries, may help to relieve the emotional strains upon the hemophiliac and his family. Hemophilic children of today and future generations may be spared these complications.

In short, the management of hemophilia is a whole new ball game!

References

1. Weiss AE, Brinkhous KM: Pathogenesis and incidence of the hemophilias, in McCollough NC (ed): *Comprehensive Management of Musculoskeletal Disorders in Hemophilia*, Washington DC, Natl Acad Sci, 1973, pp 3-16.
2. US National Heart and Lung Institute: *Blood Resource Studies. Summary Report*. D.H.E.W. Publ No. (N.I.H.) 73-716, US Govt Printing Office, 1972.
3. Weiss AE, Brinkhous KM: Hemarthroses and hemarthropathy in hemophilia A and B: Pathologic alterations and their amelioration by prompt transfusion therapy, in McCollough NC (ed): *Comprehensive Management of Musculoskeletal Disorders in Hemophilia*, Washington DC, Natl Acad Sci, 1973, pp 23-32.
4. Agle DP, Mattsson A: Psychiatric and social care of patients with hereditary hemorrhagic disease, in Ratnoff OD (ed): *Treatment of Hemorrhagic Disorders*, New York, Harper & Row, 1968, pp 111-124.
5. Brinkhous KM: Changing prospects for children with hemophilia. *Children* 17:222-227. 1970.
6. Levine PH, Britten AFH: Supervised patient-management of hemophilia: A study of 45 patients with hemophilia A

- and B. *Ann Intern Med* 78:195-201, 1973.
7. Kasper CK, Dietrich SL, Rapaport SI: Hemophilia prophylaxis with factor VIII concentrate. *Arch Intern Med* 125:1004-1009, 1970.
 8. Katz AH: Hemophilia: *A Study in Hope and Reality*, Springfield Ill, C C Thomas, 1970.
 9. Roberts HR, Weiss AE: Hemophilia and hemophilioid disorders: Method of Harold R Roberts, MD and Andrew E. Weiss, MD, in Conn HF (ed): *Current Therapy*, Philadelphia, Saunders, 1972, pp 256-260.
 10. Graham JB, Buckwalter JA, Hartley LJ, et al: Canine hemophilia. Observations on the course, the clotting anomaly, and the effect of blood transfusions. *J Exp Med* 90:97-111, 1949.
 11. Ali AM, Gandy RH, Britten MI, et al: Joint haemorrhage in hemophilia: Is full advantage taken of plasma therapy? *Br Med J* 3:828-831, 1967.
 12. Brinkhous KM, Swanton MD, Webster WP, et al: Hemophilic arthropathy: Transfusion therapy in its amelioration—canine and human studies, in Vanderfield IR (ed): *Proceedings of Symposium on Hemophilia*. Hemophilia Society of N.S.W., Sidney, Australia, 1966, pp 18-21.
 13. Rabiner SF, Telfer MC: Home transfusion for patients with hemophilia A. *N Engl J Med* 283:1011-1015, 1970.
 14. Lazerson J: The prophylactic approach to hemophilia A. *Hosp Pract* 6:99-109, 1971.
 15. Van Eys J: Home management of hemophilia A. *J Tenn Med Assoc* 64:407-410, 1971.
 16. Sergis E, Hilgartner MW: Hemophilia. *Am J Nurs* 72:2011-2017, 1972.
 17. Lazerson J: Hemophilia home transfusion program: Effect on school attendance. *J Pediatr* 81:330-332, 1972.
 18. Levine PH: Efficacy of self-therapy in hemophilia: A study of 72 patients with hemophilia A and B. *N Engl J Med* 291:1381-1384, 1974.
 19. Lazerson J: Hemophilia home transfusion program: Effect on cryoprecipitate utilization. *J Pediatr* 82:857-859, 1973.



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Hypercortisolism: Adrenal Adenoma Versus Carcinoma

Karen C. Krueger, M.D.
Robert W. Almoney, M.D.
Janet K. Bixel, M.D.

A 22-year-old woman was hospitalized for evaluation of secondary amenorrhea, mild increase in facial hair, fullness of her face, and exacerbations of her acne. Laboratory results revealed nonsuppressible 17-OHCS and 17-KS with high-dose dexamethasone. Angiography revealed a large right adrenal mass with possible neovascularization involving the liver, consistent with carcinoma. The liver scan also was consistent with metastatic disease. At surgery, a 10-cm, encapsulated tumor was readily removed with no evidence of metastatic liver involvement. Histopathology was consistent with an adrenal adenoma. The clinical, laboratory, angiographic, and isotope-scanning procedures must be done to help differentiate adenoma from carcinoma and to delineate the surgical approach to adrenal tumors. As this case discloses, these studies still may be misleading, and one must ultimately rely on a tissue diagnosis. Otherwise, a patient might be subjected to palliative rather than curative treatment.

Editor's Note: The presence of amenorrhea following discontinuance of oral contraceptives in the patient presented by the authors provides a situation confronting many physicians today. The careful work-up and surgical follow-up makes this case report worthy of presentation.

A UNILATERAL ADRENAL TUMOR weighing more than 150 to 200 gm and measuring more than 7 to 8 cm in diameter should be considered as potentially malignant.¹ Scott, et al² suggested that carcinoma must be suspected in patients with hypercortisolism due to an adrenocortical tumor when basal urinary 17-ketosteroid (17-KS) levels are extremely high (40 to 100 mg/day). We report the case of a young woman who fulfilled these criteria and who also showed radiographic evidence highly suspicious of a unilateral adrenal carcinoma. At surgery, a large, well-encapsulated, benign-appearing, right adrenal cortical adenoma was removed.

Methods

Plasma cortisol levels were determined by the modified Mattingly technique and the use of the Turner Fluorimeter.^{TM3,4} Urinary corticosteroid determinations used the modified Porter-Silber colorimetry for 17-hydroxycorticosteroids (17-OHCS), and the modified Hycel Cortiset® colorimetry for 17-ketogenic (17-KG) steroids and 17-ketosteroids (17-KS).^{3,5} Urinary cre-

atinine value was determined by the Jaffee method adapted to the SMA 1260 to act as a check on the completeness of the urine collection.³ The plasma testosterone level was measured by radioimmunoassay without chromatography.⁶

Case Report

A 22-year-old white woman was admitted to Riverside Methodist Hospital in Columbus for the evaluation of five-month secondary amenorrhea following the discontinuation of a two-month course of oral contraceptives. She had had normal menstrual periods since her menarche at age 13 years, with prompt resumption of menses

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Dr. Bixel, Columbus, Attending Staff, Riverside Methodist Hospital; Courtesy Staffs, Grant, St. Anthony, and The Ohio State University Hospitals; and Clinical Assistant Professor of Medicine, The Ohio State University College of Medicine.

Submitted August 5, 1975.



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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

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Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Foot of patient with acute gouty arthritis as seen by conventional x-ray.



Scintiphotograph of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal

joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

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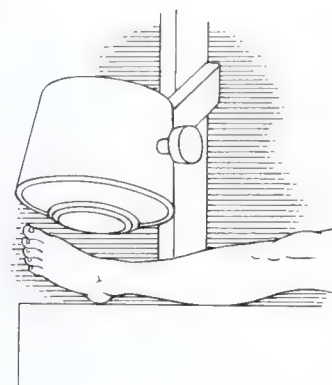
INDOCIN is a potent drug with anti-inflammatory, antipyretic, and analgesic properties. It should not be used in conditions other than those recommended. Although INDOCIN does not alter the progressive course of the underlying disease, in selected patients with acute gouty arthritis it has been found highly effective in relieving pain and in reducing fever, swelling, and tenderness.

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For a brief summary of prescribing information, please see following page.

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Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

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and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of pre-existing sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angitis; pruritus; urticaria; angioedema; skin rashes; purpura.

Ear Reactions: Hearing disturbances, deafness, tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

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Urinary Corticosteroid Activity After Low- and High-Dose Dexamethasone Suppression Test

	17-OHCS (Normal=2-10) mg/24 hr	17-KG (Normal=3-16) mg/24 hr	17-KS (Normal=5-15) mg/24 hr
Initial inpatient value	18.3	27.3	36.0
Low dose	20.8	30.4	24.4
High dose			
Day 1	22.2	29.2	37.4
Day 2	26.3	36.6	36.3

following the birth of a healthy baby in 1970, and after discontinuing oral contraceptives in 1971. During the five-month history of amenorrhea, she also noted an increasing roundness of her face, the development of fine facial hair, and exacerbation of acne. Her 24-hour urinary corticosteroid levels were elevated: 17 ketogenics of 34 mg/24 hr (normal=3-16 mg/24 hr) and 17-ketosteroids of 28 mg/24 hr (normal=5-15 mg/24 hr). Physical examination on admission revealed a well-nourished, 22-year-old, white woman with downy facial hair and some facial fullness. These were more apparent when previous pictures were compared to her present appearance. The results of the rest of her examination, including pelvic and breasts, were entirely normal. Normal laboratory values included total protein; albumin; calcium; cholesterol; blood urea nitrogen (BUN); uric acid; creatinine; total bilirubin; alkaline phosphatase; lactic dehydrogenase (LDH); serum glutamic oxaloacetic transaminase (SGOT); and plasma testosterone. Her hemoglobin level was 16.2 gm/100 ml, and her hematocrit reading was 46.7 percent. An oral glucose tolerance test revealed a fasting blood glucose level of 98 mg/100 ml, 246 mg/100 ml at 1 hour, 191 mg/100 ml at 2 hours, and 98 mg/100 ml at 3 hours. At 8 AM, her plasma cortisol level was 21 μ g/100 ml (normal=5-20 μ g/100 ml), and at 8 PM, the level was 25 μ g/100 ml (normal=2-16 μ g/100 ml). Dexamethasone, 1 mg, was given at 11 PM, and the plasma cortisol level the following morning was 25 μ g/100 ml, the normal value being less than 5 μ g/100 ml.⁷ She was then started on low-dose dexamethasone suppression (0.5 mg orally every 6 hours) for two days followed by high-dose dexamethasone suppression (2 mg orally every 6 hours), and 24-hour urinary corticosteroid values were obtained.⁷ Results of this testing are shown in the Table. Since the nonsuppression of urinary corticosteroids was compatible with the presence of an adrenal tumor, an intravenous pyelogram was performed. This showed flattening of the superior pole of the right kidney. Adrenal venography and selective arteriography demonstrated a large, highly vascular, mass lesion occupying the right adrenal gland (Fig. 1). The size of the mass, the neovascularization seen, and the substantial elevation of 17-ketosteroids were consistent with an adrenal carcinoma. An extensive investi-



FIG. 1. Adrenal arteriography showing highly vascular lesion occupying right adrenal gland.

gation then was undertaken to delineate the possibility of metastatic lesions. A liver scan showed several large filling defects in the right lobe of the liver consistent with a metastatic process (Fig. 2). An inferior vena-cavogram revealed a rather marked area of compression at the level of the entry of the hepatic veins with compression of the hepatic veins themselves. It was uncertain whether this represented invasion or compression by the patient's right adrenal tumor. An aggressive surgical approach using a thoracoabdominal incision was advocated in view of the age and otherwise good health of the patient. The preoperative plan was to attempt a right



FIG. 2. Liver scan showing large filling defect in right lobe of liver.

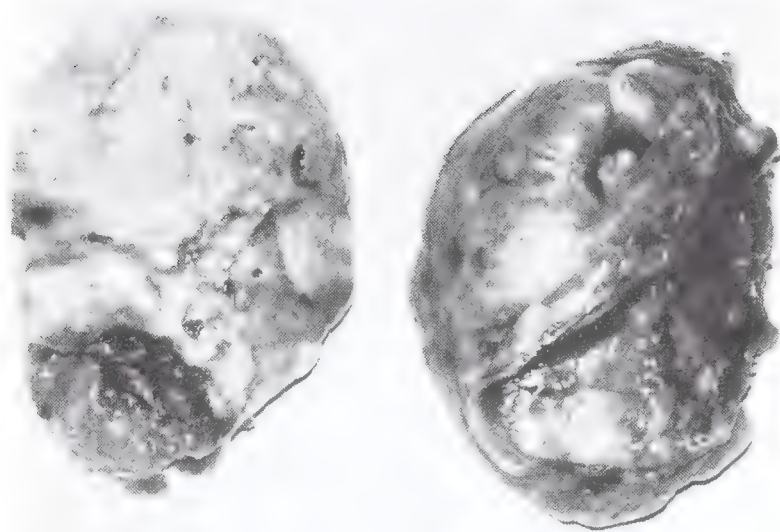


FIG. 3. Gross specimen of adrenal tumor which measured 10X7.5X6 cm and weighed 226 gm.

hepatic lobectomy, right adrenalectomy, and right nephrectomy if possible. However, at surgery, a well-encapsulated tumor measuring 10X7.5X6 cm and weighing 226 gm was removed without difficulty (Fig. 3). The liver was grossly free of metastases. The pathologic diagnosis was cortical adenoma, histologically classified as benign.

Discussion

Glenn and Mannix¹ and Scott² believed that concurrent clinical, endocrinologic, and radiographic studies in patient's with Cushing's syndrome due to an adrenocortical tumor could help to differentiate benign adrenal adenoma from adrenocortical carcinoma before operation. When a benign adenoma appeared likely after clinical, endocrinologic, and radiographic evaluation, Scott and his associates² advocated the use of a posterior retroperitoneal surgical approach. However, when carcinoma of the adrenal gland appeared likely on preoperative study, they recommended a thoracoabdominal approach with a radical, nonmanipulative, en bloc resection of the tumor and involved structures, and organs if possible. In their series of 28 patients, 18 had benign adrenal adenomas and ten had adrenal carcinoma. They obtained a curative resection in three patients with adrenal carcinoma. Three other patients with adrenal carcinoma underwent resection with recurrences ten months to three years after surgery.²

Glenn and Mannix^{1,8} also favored a surgical approach to adrenal tumors. In cases of adrenal carcinoma with metastases, they employed surgical exploration with the removal of as much tumor as possible. For example, a tumor which involved the left adrenal gland would merit the resection of spleen and kidney so that a valid

palliation could be obtained.¹ We support the conclusion of Glenn, Mannix, et al, and Scott,^{1,2,8} that considerable accuracy has been achieved in localizing and visualizing adrenalcortical tumors before operation and that complete radiographic, endocrinologic, and clinical evaluation is mandatory to delineate the nature of the tumor and to aid the surgeon in his approach to resection.

Since our patient's radiographic, endocrinologic, and angiographic studies were compatible with the diagnosis of a right adrenal carcinoma with extension into the right lobe of the liver, a thoracoabdominal surgical approach was employed with the possibility of an en bloc resection of the right lobe of the liver, right kidney, and right adrenal gland. This approach to resection was a chance for a curative procedure, but was unnecessary since, at surgery, the tumor appeared to be benign. The diagnosis of a benign-versus-malignant adrenal tumor is a difficult one to make on histopathologic grounds alone. Glenn and Mannix¹ reported a similar well-encapsulated, large adrenal tumor, histologically classified as benign, which recurred with lung metastasis six months after surgical resection. Therefore, there still remains the need for close clinical and endocrinologic observation of these patients.

Our patient's preoperative studies did not appear to differentiate a benign adrenal adenoma from an adrenocortical carcinoma. However, a thorough investigation with the forementioned studies are in order to determine the possible presence and extent of metastatic disease and, thus, as our case discloses, a curative rather than a palliative procedure could be obtained.

We advocate the thorough endocrinologic and radiographic investigation of patients with adrenal tumors in the attempt to delineate the nature of the tumor and to aid the surgeon in his approach to resection. We also emphasize the need for an aggressive surgical approach in the management of adrenocortical tumors.

References

1. Glenn F, Mannix H Jr: Diagnosis and prognosis of Cushing's syndrome. *Surg Gynecol Obstet* 126:765-776, 1968.
2. Scott HW Jr, Foster JH, Rhamy RK, et al: Surgical management of adrenocortical tumors with Cushing's syndrome. *Ann Surg* 175:892-905, 1971.
3. Tietz N: *Fundamentals of Clinical Chemistry*, Philadelphia, Saunders, 1970, pp 503-504, 508-511, 722-726.
4. Mattingly D: A simple fluorimetric method for the estimation of free 11-hydroxycorticoids in human plasma. *J Clin Pathol* 15:374-379, 1962.
5. Varley H (ed): *Practical Clinical Chemistry* (ed 3), New York, Interscience, 1935, pp 233-257.
6. Ismail AA, Niswender GD, Midgley AR Jr: Radioimmunoassay of testosterone without chromatography. *J Clin Endocrinol Metab* 34:177-184, 1972.
7. Melby JC: Assessment of adrenocortical function. *N Engl J Med* 285:737-739, 1971.
8. Glenn F, Horwith M, Peterson RE, et al: Total adrenalectomy for Cushing's disease. *Ann Surg* 175:948-955, 1972.

Coronary Care Unit Monitoring by Technicians

Andrew P. Klaus, M.D.
Wallace L. Horton
Norma Wanamaker, R.N.

Technicians were trained to watch cardiac monitors to detect cardiac arrhythmias and to alert the coronary care unit (CCU) nurses. This afforded the CCU nurses more time to spend with bedside nursing and made it possible to monitor cardiac patients from other locations in the hospital. No additional CCU nurses were required and, since a trained observer was always watching the monitor, the detection of arrhythmia improved.

CONTINUOUS electrocardiographic monitoring is useful only if there is a reliable observer watching and checking the monitors constantly. Traditionally, this role was filled by the coronary care unit (CCU) nurses who have amply demonstrated their ability to diagnose complex cardiac arrhythmias. However, the CCU nurse has responsibilities and duties other than watching the monitor. A recent study in a university hospital demonstrated that serious ventricular arrhythmias recorded by a 24-hour Holter™* tape were missed initially by the nurses in 24 of 29 cases. The time delay from first occurrence of these arrhythmias to recognition by the conventional monitoring system averaged ten hours.¹

It is not unusual for all of the nurses in a CCU to be busy at the bedside of various patients, while no one is

watching the central monitor. When the nurses are away from the central monitor, great reliance is placed on the alarm system which only detects abrupt changes in heart rate. The alarms do not detect transient rhythm changes or premature ventricular contractions that are not of sufficient frequency to set off the alarm.

The introduction of "progressive coronary care" with electrocardiographic monitoring of ambulatory patients by telemetry from various points in the hospital has uncovered occasional serious arrhythmias. This system too requires a constant attendant at the central monitor.

Methods

Our hospital has two intensive care facilities. A six-bed intensive care unit (ICU) is used for those patients requiring intensive, but not necessarily cardiac care. The cardiac special care unit (CSCU) is designed to provide comprehensive cardiac care. Telemetry antennae have been located in strategic areas throughout the hospital to afford cardiac rhythm monitoring of those patients not in the CSCU. Patients can be monitored in the ICU, the surgical recovery room, the emergency room, two regular hospital rooms, and also as they ambulate along one corridor. The central monitoring station for all these areas is in the CSCU.

To maximize the use of the specially trained cardiovascular nurses and to allow them more time for bedside nursing as well as to provide constant observation of the central monitor, a new member of the cardiac care team was introduced. These individuals, called cardiac monitor technicians, have the primary function of watching the central cardiac monitor. They were recruited from the

From the Department of Cardiology, Community Memorial Hospital, Marion, Ohio.

Dr. Klaus, Columbus, formerly Director of Cardiac Special Care Unit, and Chief of Cardiology, Community Memorial Hospital.

Mr. Horton, Newark, Medical Electronics Consultant.

Ms. Wanamaker, Marion, Directress of Nursing, Community Memorial Hospital.

Submitted August 19, 1975.

ranks of the hospital orderlies and nurses' aides. They received an intensive training course in basic cardiac physiology, in the recognition of a normal electrocardiographic pattern, and how to recognize a change from this prevailing pattern. Instruction in the recognition of common cardiac arrhythmias was given but not emphasized since the CCU nurses would be available immediately for diagnosis.

Two monitoring technicians are assigned to each nursing shift; one is always stationed at the central monitor. The other monitor technician assists the nursing staff when not stationed at the monitor. We have found that rotation about every 45 minutes is optimal to prevent fatigue.

Each monitored patient, whether in the CSCU or elsewhere, has a bedside cardiac monitor. An audible and visual alarm system, originating at the central facility, indicates the precise location of any alarm. The alarm system can be triggered automatically by an abrupt rate change in any of the monitors, or it can be initiated manually by the central station.

Communication with the nurses in any of these areas is accomplished by a telephone "hot line" system. This is a continuous open line with one receiver at the central monitoring station and the others located at each bedside allocated to cardiac monitoring. In the case of a patient alarm, the attending nurse has immediate telephone communication capability from bedside to the central station and to the head nurse of the CSCU. Once initiated, the alarm can only be removed by the central station technician and, therefore, the call-in assures a response. The monitor technician can also signal the nursing staff and direct them to the appropriate patient, and the nursing staff can signal the central monitoring station. This system has enabled us to concentrate all of our trained cardiovascular nurses in the cardiac special care unit. By having instant communication with the central monitoring station and with the cardiovascular nurses in the CSCU, the nurses trained in intensive care or other specialized areas

-but not in cardiac care—still can function effectively and attend cardiac patients in these areas.

Results

This system has worked extremely well. It has enabled the cardiovascular nurses to devote more time to bedside nursing without the worry of leaving the central monitor. It now is possible to extend cardiac monitoring to other areas of the hospital without requiring additional specially trained cardiovascular nurses. The cost, other than the equipment investment, has been limited to the addition of one orderly or nurses' aide to the CSCU staff since one technician can perform these tasks when not at the monitor. The monitor technicians have become very adept at arrhythmia detection and diagnosis and have advanced far beyond their initial training. Although a systematic study prior to the introduction of the technicians was not made, we have the distinct impression that the recognition of potentially serious arrhythmias has improved.

Conclusions

Theoretically, the best system for monitor observation would be an automated computerized system. However, present-day computer arrhythmia-detection systems have not yet been shown to reliably detect all types of arrhythmia.² The systems available are quite expensive.

In our hospital, the cardiac monitor technicians have proved to be a reliable alternative and are a very useful addition to the cardiac care team.

References

1. Romhilt DW, Bloomfield SS, Chou TC, et al: Unreliability of conventional electrocardiographic monitoring for arrhythmia detection in coronary care units. *Am J Cardiol* 31:457-461, 1973.
2. Corday E, Lang TW: Accuracy of data reduction systems for diagnosis and quantification of arrhythmias. *Am J Cardiol* 35:927-928, 1975.



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COLLEAGUES IN THE NEWS . . .

Five Ohio physicians received certificates of appreciation at the quarterly meeting of the Ohio Valley Health Services Foundation Board of Trustees held during December. Those honored are **WILLIAM H. ALLEN, JR., M.D.**, Athens; **ALVIN HAMBRICK, M.D.**, Jackson; **THOMAS W. MORGAN, M.D.**, Gallopis; **A. BURTON PAYNE, M.D.**, Ironton; and **THOMAS PRICE, M.D.**, Logan.

The certificates were awarded in recognition "for selfless and avid enthusiasm" displayed by the recipients while serving as chairmen of levy campaigns in support of the region's Southeast Ohio Emergency Medical Services system.

ROBERT E. HOLLAND, M.D., has resigned his post as Director of the Chillicothe Veterans Administration Hospital to become Chief of Staff at the Veterans Hospital at Leavenworth, Kansas. Dr. Holland is a member of the Board of Trustees of the Mid-Ohio Health Planning Federation.

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WILLIAM H. HOLLOWAY, M.D., has been elected to a two-year term as president of the 10,000 member International Transactional Analysis Association.

Dr. Holloway has practiced in Akron for 18 years and moved to Medina in 1973. He serves as psychiatric consultant to the Community Mental Health Services of Medina, Inc.

C. WILLIAM KECK, M.D., is the new Health Director of Akron. Dr. Keck also has been appointed to the faculty of Northeastern Ohio Universities College of Medicine where he will develop curriculum and teach community medicine.

Dr. Keck takes over the directorship from his positions as field professor of community medicine for the Department of Community Medicine at the University of Kentucky's Medical College and health officer of the Kentucky River District Health Department.

Retiring as Health Director is **JOHN D. MORLEY, M.D.** Dr. Morley was recently granted honorary membership in the Summit County Medical Society. The few individuals selected for this membership must be distinguished members of the medical profession or have contributed notable service to the community.

The Council of the Summit County Medical Society voted unanimously to confer this honor upon Dr. Morley, and he was presented a plaque at a reception held in his honor by the city of Akron.

After 32 years in the practice of general surgery in Alliance, **ROBERT KING, M.D.**, has retired. He was honored at a dinner held by members of the Alliance City Hospital medical staff.

Until his retirement Dr. King served as Chief of Surgery at Alliance City Hospital. He has also been team physician for both Alliance High School and Mount Union College.

WILLIAM VIGOR, M.D., who has lived and practiced in Brecksville since 1933, retired from practice at the close of 1975. Dr. Vigor also served as athletic trainer at Brecksville High School from 1933 to 1973.

JEROME F. WIOT, M.D., of Cincinnati, has been nominated for a three-year term on the Board of Chancellors of the American College of Radiology. The Nominating Committee of the college released its slate of officers in late 1975.

RICHARD ZOLLINGER, M.D., Chairman of the Mt. Carmel Medical Center Department of Surgery, Columbus, has been elected Vice-President of the Western Surgical Society. Membership in this organization, composed of surgeons from the western area of the U.S., is by invitation only. Dr. Zollinger has been a member for the last 20 years.

Creative Living: A Bright Future for the Quadriplegic

During the year and one-half since the Creative Living complex opened in Columbus, much has been written of this remarkable facility. The unit was designed to solve the housing problems of the severely physically disabled individual. Residents are quadriplegic thereby needing assistance to perform the activities of daily living.

It is extremely difficult for a quadriplegic individual to find adequate housing and reliable people to assist him. Therefore, prior to the inception of Creative Living, many of the residents either lived with their parents or in nursing homes. These situations did not foster a bright outlook on life for the disabled person as he was confined with much older individuals, lacked privacy, and did not have any type of independent lifestyle. When living with parents who were serving in the assistant capacity, the added problem arose that those parents would eventually be unable to perform the tasks necessary.

Housing 18 young people, Creative Living provides individual living units designed to meet the needs of the quadriplegic and to give him an amount of independence. The facility is ideally located due to its proximity to educational facilities, job opportunities, and supportive medical facilities. Creative Living is unique in its private apartment concept: each unit contains a living room, bedroom, kitchenette, and bath. The apartments all face an interior courtyard. Designed as an intermediary, Creative Living hopefully provides transition for the quadriplegic from rehabilitation to return to his home community or other location.

Of the 17 residents now in the facility, nine are students at The Ohio State University, three participate in vocational training, and five are employed. Most of these residents, whose average age is 30, receive financing from the Bureau of Vocational Rehabilitation. These



Mr. Jack Dacre

young men and women are spectacular in their enthusiasm for life and in their accomplishments.

Miss Carol Sue Cyrus suffered a spinal cord injury in 1956. She is a quadriplegic and had lived at home until the Creative Living Center opened. She works part-time as the receptionist at Dodd Hall and attends Ohio State studying social work.

Miss Cyrus described Creative Living as "The greatest thing that ever happened to me; it opened all kinds of doors that had been closed."

Another resident, Mr. Thomas Tedeschi, was made quadriplegic in a diving accident two years ago. He has made a remarkably rapid recovery and is now completing his studies in business administration at Ohio State.

Miss Gene Prichard from Lima, Ohio, contracted polio as a child. She went on to graduate summa cum laude from Ohio State and is employed by the State Board of Education. Miss Prichard tutors patients at Dodd Hall and, additionally, serves as resident manager of Creative Living. In this position she handles all complaints ranging from leaky faucets to personal problems. Anything she cannot handle is referred to the Creative Living Executive Committee.

Miss Beverly Baer is also a victim of polio. She earned a masters degree in social work from the University of Missouri and employs that knowledge as a part-time social worker in the Ohio State Cancer Rehabilitation Project. Before coming to Creative Living, Miss Baer lived at home concentrating on drawing, painting, and working at odd jobs.

Mr. Jack Dacre, Executive Secretary of Creative Living, suffered a spinal cord injury in an automobile accident ten years ago. When asked what the Ohio physician could do to advance the cause of the quadriplegic, Mr. Dacre replied, "Be aware of the physical and socio-



Mr. Thomas Tedeschi

economic problems that face the quadriplegic.”

Mr. Dacre noted that not every college of medicine is fortunate enough to have a department of physical medicine similar to the one at The Ohio State University. Ernest Johnson, M.D., Chairman of the OSU Department of Physical Medicine, tries to instill an awareness of the physically disabled in his students and housestaff. He stresses that the physically disabled are individuals and should be treated as such.



Miss Carol Sue Cyrus

The spinal-cord-injured individual is probably at the greatest disadvantage, continued Mr. Dacre. There are approximately 100,000 individuals with this injury in the U.S. All other nervous system diseases are far in the forefront due to media exposure during fund-raising campaigns. In addition, the spinal-cord-injured patient is usually quite young when the injury occurs: the average age being 20½ years. These young people must learn to face life knowing that one minute they were fine and the next paralyzed.

Physicians are often not aware of resources available for assisting the severely disabled, stated Mr. Dacre. If an Ohio physician does not know whom to contact for assistance in dealing with a disabled patient, he should direct the person to a physiatrist. Mr. Dacre noted, “If a severely physically disabled person cannot be assisted by the comprehensive services afforded by Dodd Hall, its physicians, and staff, then I have no idea what other facility in the state of Ohio could.”

The philosophy behind Creative Living was developed by Dr. Johnson, Mr. Kenneth Hamilton, Associate Professor of Social Work at The Ohio State University, and Mrs. John W. Dickhaut, Columbus community and civic leader. Mr. Charles Frank, Chairman of the Board of Trustees of Creative Living, was the design architect.

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Ohio Health News

John H. Ackerman, M.D., M.P.H.

Director of Health

Chronic Diseases

More than one million individuals in Ohio have chronic physical disabilities: high blood pressure, cancer, diabetes, lung or kidney disease. This category includes 85 percent of those over 65 years of age.

Death due to cancer occurs every half hour in Ohio, making cancer the second leading cause of death in the state. Early detection and screening programs for childhood, cervical, and breast cancer are being expanded by the Ohio Department of Health to combat this problem.

Last year heart disease, the leading cause of death in Ohio, accounted for 39,644 deaths. High blood pressure was a factor in 50 percent of these deaths.

Rheumatic fever is the one kind of heart disease that is preventable. There were 597 cases of rheumatic fever in 1974, about half the number recorded annually ten years ago. The Department supplies continuous dosages of penicillin or sulfadiazine for more than 20,000 Ohioans who have had one or more attacks of rheumatic fever in an effort to prevent further heart damage.

A total of 10,715 people died from strokes, the third

leading cause of death. Individuals with high blood pressure have five times as much chance of having a stroke. The stroke death rate is three to four times greater for non-whites. The Ohio Department of Health program is aimed at reducing the serious consequences associated with uncontrolled high blood pressure by identifying victims.

Diabetes, an inherited, incurable, and lifetime disease, is the sixth cause of death among Ohioans. Although there is no known cure for diabetes, it can be controlled. The Department conducts screening programs throughout the state and sponsors classes for newly diagnosed diabetics and their families to help them better understand the disease. Instruction in diet management and drug administration is provided as well as information on how to recognize complications.

Venereal Disease

Detection, treatment, and education programs in venereal disease have been expanded throughout the state in an effort to reverse the upward trend in gonorrhea.

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RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

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rhea infections and to continue the decline in infectious syphilis infections.

In 1974, there were 36,393 cases of gonorrhea reported in Ohio compared to 30,113 in 1973. This is a 20 percent increase. There were 279 cases of syphilis reported, which represents a decrease of 4.8 percent from the previous year.

Factors which have contributed to the increases in reported gonorrhea during the last several years in Ohio include an intensive screening program and the interviewing of infected males for their sexual contacts. During 1974, a total of 434,857 persons were screened, resulting in 16,777 women being detected with gonorrhea. Additionally, 12,985 infected males were interviewed and as a result of contact follow-up, 3,280 persons received treatment. Many of those identified were teenagers.

Immunization

No child in Ohio should remain vulnerable to polio, measles, rubella, diphtheria, pertussis, tetanus, and other childhood diseases. Yet, according to recent surveys, 60 percent of Ohio preschoolers are not adequately immunized against the childhood diseases.

The assumption that these diseases have been conquered and that there is nothing to worry about is wrong.

Abortion Regulations

Effective September 1, 1975, the Public Health Council of the Ohio Department of Health adopted regulations on abortion in compliance with section 3701.341 of the Ohio Revised Code (part of the Ohio Abortion Law, Am. Sub. H.B. 989, 110th General Assembly). These regulations were published in the September 1975 issue of *The Journal*.

Regulation HE-4-03 dealing with "Reporting Forms" is apparently in need of clarification and emphasis. The abortion report forms must be completed in full for all induced and therapeutic abortions performed by a physician in Ohio. The physician performing the abortion is required to sign the completed form.

The abortion report is kept strictly confidential. The Ohio Department of Health is solely interested in gathering aggregate statistics which will be compiled and published at the end of each fiscal year.

Since the abortion report form is mandated by law, it is the responsibility of each physician performing abortions to insure that they are completed and signed for each woman receiving an abortion. These report forms must be sent to the Ohio Department of Health, Confidential Reports A, 450 East Town Street, Columbus, Ohio, with 15 days after the completion of the abortion.

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ease, dehydration, heat cramps and hyperkalemia.

Warnings: Do not use excessively.

Precautions: Administer with caution and adjust to the requirements of the individual patient. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis. **Patients should be cautioned to adhere to dilution instructions.**

Adverse Reactions: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs,

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One 15 ml. tablespoonful (20 meq. of potassium chloride) *diluted* in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician.

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Exhibits will be set up and viewed at the Cincinnati Convention & Exposition Center, 200 West Fifth Street, Cincinnati, Ohio. Exhibit Days and Times will be as follows: Monday, May 10 — 12:00 Noon - 4:30 P.M.; Tuesday, May 11 — 9:00 A.M. - 4:30 P.M.; and Wednesday, May 12 — 9:00 A.M. - 3:00 P.M.

Mail applications to the attention of John E. Albers, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

APPLICATION FOR SPACE SCIENTIFIC EXHIBITS

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Unsolicited Multiphasic Screening Test Results

George I. Meisel, Legal Counsel, Cleveland Academy of Medicine

Many Ohio physicians have been receiving unsolicited medical test results from multiphasic screening centers and organizations. These tests either are performed at the patient's direct request or are provided by third parties for the patient. In practically all cases the test results are forwarded to the physician in the absence of any request or even knowledge on the part of the physician that the tests have been performed.

According to H. Allan Bloomer, M.D., in an article published in the *Utah Bulletin* (Fall, 1975), "Multiphasic screening (MPS) is the application of several tests, usually a battery of biochemical analyses, to large groups of apparently well persons in an attempt to sort out those who have a disease from those who do not. The emphasis is upon detecting abnormality rather than arriving at a specific diagnosis or course of action. Thus, MPS differs from the periodic health examination in which physician knowledge and judgment are integral parts of the service provided."

The receipt of such unsolicited MPS test results requires a response by the physician. Although the response may vary depending upon the circumstances of the physician-patient relationship and the physician's own situation, it should be emphasized that an appropriate response must be made by the physician in order to guard against the possibility of legal liability.

The physician's response to unsolicited MPS test results may take one of the following forms:

Physician-Patient Relationship Exists and Physician Wishes to Continue It

If a physician receives MPS test results from a current patient and he wishes to continue the physician-patient relationship, he should respond to the results with a letter such as the following:

I have received a report from (testing organization) of certain examinations and tests recently made for you and which, I understand, were forwarded to me at your request. I would suggest that you make an appointment with my office to discuss this report.

It should be noted that this form should be used even when the test results indicate no need for further testing or medical treatment. This information should be given the patient in person by the physician.

If the reports indicate physical conditions which might require medical treatment, the physician should ordinarily arrange for further testing and examination under his direction before rendering medical service.

Physician-Patient Relationship Exists But Physician Wishes to Terminate It

If a physician receives MPS test results from a patient and refuses to accept these reports where action would be reasonably expected, the physician may be ex-

posed to a claim of malpractice by the patient. If the physician does not wish to act upon the test results, he should terminate the physician-patient relationships as follows:

I have received from (testing organization) a report of certain examinations and tests recently made for you and which, I understand, were forwarded to me at your request.

I have not examined these reports and have returned them to (testing organization). I would suggest that you make arrangements with another physician to examine this report and consult with you in regard thereto.

Physician-Patient Relationship Is Not Current and Physician Does Not Desire to Reactivate It

If there has been no recent physician-patient relationship and the physician does not desire to reactivate such a relationship, the physician can refuse to accept testing reports with appropriate notice as follows:

I have received from (testing organization) a report of certain examinations and tests recently made for you and which, I understand were forwarded to me at your request.

My records indicate that your last visit to my office was on (DATE). Under these circumstances, I have not read the report and have returned it to (testing organization). I would suggest that you arrange with another physician to examine this report and consult with you in regard thereto.

Physician-Patient Relationship Never Existed

Since a physician has the right to select his patients, the fact that a would-be patient has given the physician's name to a testing organization does not create a physician-patient relationship where none has heretofore existed. The physician can refuse to accept testing reports as follows:

I have received from (testing organization) a report of certain examinations and tests recently made for you and which, I understand, were forwarded to me at your request.

My records do not indicate that you have ever been a patient of mine and I, therefore, have returned the report to (testing organization). I would suggest that you make arrangements with another physician to examine this report and consult with you in regard thereto.

We have tried in this article to call attention to a problem of increasing concern to many Ohio physicians—the receipt of unsolicited MPS test results—and to suggest appropriate responses. We suggest, however, that physicians consult with their own legal counsel before determining what the appropriate response under the facts and circumstances of a particular case should be when an unsolicited MPS test result is received.

OSMA Annual Meeting Theme "Medical Spirit of '76"

Gail Dodson, OSMA Covention Coordinator

"Medical Spirit of '76" has been chosen as the 1976 Ohio State Medical Association Annual Meeting theme. The Annual Meeting will be held Sunday, May 9, through Wednesday, May 12, at the Stouffer's Cincinnati Tower and the Cincinnati Convention and Exposition Center. Practically all OSMA Scientific Sections as well as many of the Specialty Groups will participate by sponsoring scientific programs in connection with the Annual Meeting.

HOUSE OF DELEGATES

The meeting will start with the opening session of the House of Delegates on Sunday, May 9. The final session will be held on Wednesday afternoon, May 12. Registration for those attending the House of Delegates will open at 3 PM on Sunday, May 9. A dinner for those attending the House of Delegates in an official capacity will be served at 5:30 PM on Sunday, May 9. The opening session will get underway at 6:30 PM. All members of the association are invited and encouraged to attend the district caucus meetings of their district as well as the opening session of the House of Delegates. Councilor District Caucus meetings will be held in hotel suites assigned to councilors.

Immediately following the Opening Session will be a reception for all OSMA members, spouses, and guests. This is an innovative idea and provides members an opportunity to visit with colleagues and friends.



Pictured left to right at the OSMA 1975 Annual Meeting: George Bates, M.D.; Mr. James Pohlman; James Henry, M.D.; Mr. Hart Page; and Maurice Lieber, M.D.

REFERENCE COMMITTEE HEARINGS

The hearings will start at 8:30 AM on Monday, May 10, in rooms designated in the Annual Meeting program. Hearings will continue on Monday afternoon.

EXHIBITS

Ohio has built a reputation for its outstanding Annual Meeting exhibits. Featured will be scientific, health education, and technical exhibits. The technical exhibits are sponsored by many pharmaceutical manufacturers and other suppliers of physicians' needs. Exhibits will be open Monday, May 10, from 12 noon to 4:30 PM; Tuesday, May 11, from 9 AM to 4:30 PM; and Wednesday, May 12, from 9 AM to 3 PM.

A number of the 1976 scientific programs scheduled during the Annual Meeting will be eligible for Category 1 credit. Those which have been reported at this time include:

Course One: Clinical Management of Electrolyte and Acid Base Disturbances

Course Two: Principles of Electrophysiology

Course Three: Chemotherapy of Infections

Course Four: Vascular Diseases

Course Five: Noninvasive Diagnosis of Heart Disease

Course Six: Sexual Counseling

Course Seven: Business Management in Doctor's Office

Course Eight: Chronic Obstructive Lung Disease

Course Nine: Office Management of Headaches

Course Ten: Cardiopulmonary Resuscitation.

More information on courses and detailed programs will appear in the March issue of *The Journal*.

Space will be provided at the 1976 Annual Meeting for a Physicians' Art Show. The Art Show will be under the direction of Harry H. Fox, M.D., a Cincinnati physician. Members of OSMA and their spouses who are interested in exhibiting art pieces they personally have created or who require information regarding the exhibit should refer to the Application for Space in Art Show Exhibit which appears in this month's *Journal*.

Deadline for Submission Of Resolutions to OSMA Office Is March 10

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at

the 1976 Annual Meeting should be guided by Chapter 4, Section 8 of the OSMA Bylaws entitled "Resolutions."

"Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least 60 days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Dele-

gates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates."



Pictured left to right attending the 1975 OSMA Annual Meeting House of Delegates: John Ackerman, M.D.; Robert Smith, M.D.; and Timothy Moritz, M.D.

(continued on page 108)

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Provisions in OSMA Bylaws Pertaining to Nomination Of President-Elect

(OSMA Annual Meeting continued)

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cincinnati, May 9-12.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal*, unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 10.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect."

"Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon the filing of such candidate's name, the Executive Director shall prepare and transmit this information to each member of the House of Delegates. No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds ($\frac{2}{3}$) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal."

Resolutions involving AMA policy, when accepted by the OSMA House of Delegates, will be filed at AMA Headquarters no later than May 26.

The Ohio Delegation and Delegates from the Specialty Sections may submit resolutions for consideration by the AMA House of Delegates no later than May 26.

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Twin Beds	\$30.00
King Bed	\$32.00
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Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting May 9-12, 1976 (or for period indicated).

_____ Single Room

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_____ Double Room

Other Accommodations _____

Price Range _____

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No. of Persons _____	Arrival Date _____	Hour of Arrival _____	Departure Date _____
-------------------------	-----------------------	--------------------------	-------------------------

Name _____

Address _____

City _____ State _____ Zip _____

If Rate or Accommodation requested not available, next highest rate or accommodation will prevail.
Reservations for all Convention Groups must be received 21 days prior to arrival.
Rooms will be held until 6:00 P.M. unless payment is guaranteed.

State Medical Board of Ohio Position Paper on Hospital House Physicians

The State Medical Board of Ohio has released an updated position paper on hospital house physicians which reads:

"Section 4731.34, Revised Code, provides in part as follows:

A person shall be regarded as practicing medicine, surgery, podiatry, or midwifery within the meaning of sections 4731.01 to 4731.60, inclusive of the Revised Code, who uses the words or letters, "Dr.," "Doctor," "Professor," "M.D.," "D.S.C.," or "Pod.D.," "M.B.," or any other title in connection with his name which in any way represents him as engaged in the practice of medicine, surgery, podiatry, or midwifery, in any of its branches, or who examines or diagnoses for compensation of any kind, or prescribes, advises, recommends, administers, or dispenses for compensation of any kind, direct or indirect, a drug or medicine, appliance, mold or cast, application, operation, or treatment, of whatever nature for the cure or relief of a wound, fracture or bodily injury, infirmity or disease.

Section 4731.41, Revised Code, provides in part as follows:

No person shall practice medicine or surgery, or any of its branches without a certificate from the State Medical Board; no person shall advertise or announce himself as a practitioner of medicine or surgery, or any of its branches, without a certificate from the board; no person not being a licensee shall open or conduct an office or other place for such practice without a certificate from the board; no person shall conduct an office in the name of some person who has a certificate to practice medicine or surgery, or any of its branches.

The State Medical Board is becoming increasingly aware that in various hospitals there is a depository of foreign trained unlicensed medical graduates who do not have the qualifications to sit for the state licensing examination, or cannot pass the state licensing examination. The Board is gravely concerned that such persons or other unlicensed persons might illegally practice medicine. Again the Board restates and emphasizes that unlicensed hospital house physicians are persons prohibited from practicing medicine and surgery by the provisions of Section 4731.34 and 4731.41, Revised Code, as stated aforesaid."

According to William J. Lee, Administrator of the State Medical Board, "The Board in appropriate and justifiable situations will seek to have such persons (as described in the position paper) prosecuted."

When **impotence** due to androgenic deficiency

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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Council Approves OSMA Action On Confidentiality of Records

Following a recommendation by the Committee on Mental Health, OSMA Council has taken the following action:

1. Reaffirmed the OSMA position of preserving the confidentiality of patient medical records.
2. Requested effective communication to the OSMA membership of the dangers presented by the current (December, 1975) language of Substitute House Bill 244 in the Ohio General Assembly (to revise commitment procedures and protect the rights of hospitalized mental patients) to the confidential relationship between physician and patient.
3. Requested that physicians contact their legislators in order to call attention to this situation and to urge amendment.
4. Requested that physicians encourage their patients and other acquaintances to write individualized letters to their legislators urging amendment.
5. Requested that Governor Rhodes veto Substitute House Bill 244 if the current language pertaining to confidentiality is passed by the Ohio General Assembly.

Council's official statement emphasized that preservation of the confidentiality between physician and patient is of highest priority. OSMA's Department of State Legislation was requested to work jointly, for either amendment or new legislation, with other interested organizations including the Ohio Psychiatric Association, Ohio Hospital Association, Ohio Psychological Association, and the Ohio Department of Mental Health and Mental Retardation.

The need for OSMA action was necessitated by a section of Substitute House Bill 244 which would permit the proposed Legal Rights Service to have access to medical records of patients in Ohio's institutions for the mentally ill.

Present language would allow the Legal Rights Service "all relevant documents, information and evidence in the custody or control of the state" as well as the hospital in which the patient is currently held.

Both OSMA and the Ohio Psychiatric Association have offered an amendment to the House Judiciary Committee which would permit release of such documents and information *only with the consent of the patient*. Testimony urging adoption of the amendment has been offered by Max D. Graves, M.D., of Springfield; Victor M.

(continued on page 112)

Anabolic Stimulant Increased Muscular Tone Osteoporosis

EACH ANDROID-G TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg
Methyltestosterone	1.25 mg
L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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For a fuller, more active life!

Victoroff, M.D., of Cleveland; and George T. Harding, Jr., M.D., of Worthington.

D. Brent Mulgrew of OSMA's Department of State Legislation reported that he has outlined OSMA's position to Harry J. Lehman (D-Cleveland), Chairman of the House Judiciary Committee, and Paul R. Leonard (D-Dayton), Chairman of a Judiciary subcommittee appointed by Chairman Lehman to consider Substitute House Bill 244.

According to Milton M. Parker, M.D., of Columbus, Chairman of the OSMA Committee on Mental Health, the committee's recommendations to OSMA Council were designed to stimulate overall awareness among Ohio's physicians and to urge immediate action against the threat to breach the confidential relationship between physician and patient.

"The committee members realize that the threat to confidentiality is much broader in scope than within Substitute House Bill 244," said Dr. Parker. "We firmly believe this threat should be countered on every front whether of federal, state or local origin. Substitute House Bill 244 presents an arena where we as physicians have an opportunity to meet the challenge head-on."

California Physicians Stage Work Slowdown in Face of Liability Premium Increase

Physicians in the seven-county Los Angeles area began major work stoppages during late December and early January. This reduction in medical care came as a direct result of a requested 486 percent increase in premiums demanded by liability carrier Travelers Insurance Company. State Insurance Commissioner Wesley Kinder cut the rate hike to 327 percent, but this still put high-risk specialists at a \$27,000 annual rate.

Joseph Boyle, M.D., Speaker of the California Medical Association House of Delegates and an AMA Trustee, said that the medical staff in the seven-county area had, with one or two exceptions, voted in overwhelming numbers to limit care to emergency cases only.

When the California State Legislature convened in January, physicians pressed for additional legislation to assist themselves in dealing with the malpractice crisis. During September 1975, a special session of the legislature passed a professional liability law. In comparison to the Omnibus Malpractice Bill passed in Ohio, the California law left much to be desired.

The California liability law like the Ohio bill does provide for a Joint Underwriting Authority limited to physicians, voluntary binding arbitration, a collateral source rule, and a contingent fee schedule overseen by the state supreme court. However, the California law does not mention numerous other items that are found in the Ohio bill.

The Ohio bill provides for compulsory, nonbinding arbitration in all disputes not covered by voluntary, binding arbitration. Findings of the arbitration panel are admissible as evidence should the suit go to subsequent trial. This type of arbitration does not appear in the California legislation.

According to the Ohio bill, anyone giving expert testimony in a malpractice case must be engaged at least three-fourths of the time in either the active, clinical practice of medicine or be on the faculty of an accredited medical school. This is not contained in the California bill.

The California liability legislation also does not provide a statute of frauds. Ohio's bill states that no patient may sue a physician for any oral promise that might have been made regarding the patient's prognosis. Thus, in order to claim a breach of a contract to cure or to provide a specific result, the patient must produce a written document outlining the promise or agreement which the physician has allegedly failed to meet.

Ohio's malpractice bill also provides that the amount of damages sought by the plaintiff shall not be stated in the initial complaint. The party against whom the action is being sought may at any time request a statement setting forth the amount of damages being requested.

The liability of members or employees of utilization review committees, tissue committees, or peer review committees for actions taken in good faith as members of those committees is limited by the Ohio bill. The bill also indicates that the findings and data of these committees may not be used against a physician or hospital in a civil case. This provision ensures the confidentiality of peer review mechanisms. The California bill passed in September 1975 contained neither of these items.

Finally, Ohio's Omnibus Malpractice Bill amends the statute relating to the patient/physician relationship. When a patient brings a malpractice action against a physician or hospital, he automatically waives the patient/physician statute. All medical and hospital records are then as accessible to the defense attorney as they are to the plaintiff's attorney.

According to the California Medical Association, the California physicians that have organized the slowdown received a proposal from Governor Brown that would change the present Joint Underwriting Authority (JUA) to an exclusive JUA. This new JUA would require all physicians to pay approximately \$4,000 per year adjusted by an inflation rider and a 10 to 15 percent discretionary increase per year. This translates to a potential increase of 20 to 25 percent per year for ten years.

In addition, the Board of Directors of the JUA would be 40 percent consumer/public in membership.

As a condition to his support of the changes, Governor Brown wants physicians to serve in a California peace corps to treat patients free of charge for a number of days each month. And, he wants all physicians to agree

to accept Medi-Cal fees plus to treat Medica-Cal patients at no fee for a number of days each month. Any increase in fees would be minimal and only as the state deemed necessary. At present, Medi-Cal fees were last increased in 1969 by 2.5 percent.

Potential for the physicians to achieve their goals is doubtful. One California legislator stated flatly, "We've taken you as far as we can go."

Considering the vast differences between the Ohio and California malpractice bills, Ohio physicians can count themselves fortunate. The Ohio Omnibus Malpractice Bill passed in 1975 provides a basis to bring about reduction in the liability crisis.

Changes in OSMA-Sponsored Insurance Plans

The OSMA Council has made three important changes in the OSMA-sponsored insurance plans. The maximum benefit for group term life insurance has been increased from \$75,000 to \$100,000. A new Ohio law has removed the previous maximum of \$75,000.

A 10 percent reduction in premiums on group term life for all ages has also been approved.

The third improvement is an addition of a rehabilitation benefit at no added premium to the OSMA-sponsored disability income plan.

Members of OSMA who have questions on these changes or on any other aspect of the OSMA plans should contact Turner and Shepard, Inc., 17 South High Street, Columbus, Ohio 43215, phone (614) 228-6115.

Cincinnati and Canton Must Comply With Fluoridation Law

The Ohio Supreme Court ruled that Cincinnati and Canton must comply with a state law ordering fluoridation of municipal water supplies. Most of the other cities in the state already have complied with a 1969 law ordering fluoridation.

Self-Employed Physicians to Pay More Social Security Tax

Self-employed physicians will pay \$94.89 more to the Social Security program next year. The maximum tax level for the self-employed will be \$1,208.70, the government said. For salaried individuals the maximum tax will rise to \$895.05 from \$824.85 this year. Tax rates of 5.85 percent for each employer and employee and 7.9 percent for the self-employed will not change, but the taxable base will be increased to \$15,300 from the 1975 base of \$14,100.

A practice management workshop entitled "Establishing Yourself in Medical Practice" will be held September 14 and 15, 1976, at the Ohio State Medical Association headquarters. This workshop for young physicians planning to enter private practice is being sponsored by OSMA and cosponsored by the AMA. Interested physicians may obtain more information from Mrs. Gail Dodson, OSMA Convention Coordinator, phone (614) 228-6971.

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Ohio Towns Face M.D. Shortage

"This Town Needs A Doctor" proclaims a banner stretched across Main Street, Anytown, Ohio.

Although a sign does not appear in many localities, the physician shortage is real enough. Communities in Ohio are literally begging for medical personnel. Areas faced with physician voids make valiant efforts to attract at least one medical school graduate. These are nice towns, but each for one reason or another has to press hard for success. Some communities do reach the goal of a physician's office on Main Street. Some, however, must keep searching.

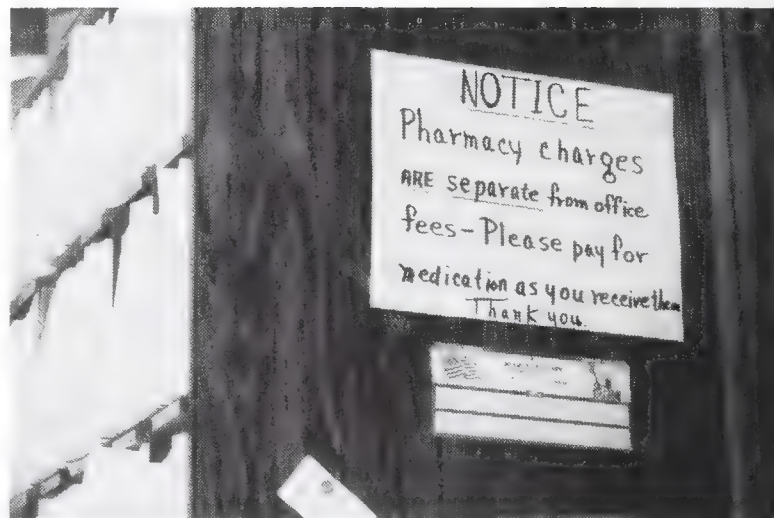
In this initial article on physician manpower in Ohio, *The Journal* will concentrate on the tactics used by a few localities in their fruitful or fruitless searches. In addition, emphasis will be placed on the assistance provided towns by county medical societies, OSMA, and Ohio medical schools.

Some towns are simply not large enough to support a physician. In these communities, the population, either already sparse or presently decreasing due to movement away from the area, is not sufficient to fill a full-time practice. In cases such as these, the town might wish to connect itself to a nearby larger area and either utilize the physicians in that town or ask that a satellite clinic be established. The larger town thereby serves as the hub of the medical wheel. If the total population of the medical wheel is large enough, specialists, in addition to primary care physicians, will probably settle in the larger area. Patients can then be easily referred from the satellite clinic to a specialist in the hub area should the need arise.

Towns in this category might also attempt to find retired physicians who would work part-time in the area. Smaller communities should not overlook the fact that they might make lovely semiretirement homes for physicians who do not wish to give up medicine completely.



James Martin, M.D., of the Forest Clinic, and patient.



The Forest Clinic office.

A town that both established satellite clinics and employed retired physicians is Kenton, Ohio. Kenton was approached to provide physician coverage for surrounding areas. Because these areas helped maintain the patient population at Kenton's hospital, the local medical academy agreed to staff medical clinics in nearby localities. In return, the academy members asked that they be relieved of emergency room duty at the hospital. The emergency room schedule was revamped, but each academy member agreed to put in four hours per week at a satellite clinic.

The Kenton physicians have not had to give the time as of yet because the group provided financing and hired physicians to cover satellite clinics that were established. A full-time physician mans the Forest Clinic on an eight-hour, five-day-a-week basis. The town of Forest provides the clinic building at nominal rent. The Kenton group owns the equipment and pays the business expenses. After two years of operation, the clinic is beginning to break even.

The Kenton physicians also hired a retired doctor to staff the Dunkirk Clinic on a part-time basis. This office is run with the assistance of a nurse practitioner. It was noted by a member of the Kenton Academy of Medicine that satellite clinics might be manned by physicians' assistants or nurse practitioners provided the clinics were furnished with closed circuit hookups with physicians in the hub town and a triage system was developed.

Other small towns have tried encouraging physician settlement by building an office. Pennsville, a small community in Morgan County, is now without a physician. Townsfolk, led by retiree Mr. G. B. Newton, have taken it upon themselves to acquire medical personnel. They are constructing an office with hopes that a physician will find attractive the fact that he can have an immediate roof over his head. The committee intends to offer this facility free of charge to the physician for the first six months. With the office partially completed, as can be

seen on this month's *Journal* cover, the community is writing physicians and medical schools and is utilizing OSMA's Placement Service to locate a physician.

OSMA's Field Service Department provides a Placement Service listing both physicians desiring location in Ohio and Ohio areas needing doctors. Additionally, the department serves as a clearing house in its efforts to identify communities in need of physicians and physicians or students interested in practicing in smaller areas.

OSMA through its component county societies is trying to identify communities that have the capacity to undertake a program of financial aid to students desiring to practice in small towns. Simultaneously, medical schools are identifying students who need such aid and would be willing to contract to return to the small community to practice for a number of years in return for financial support. It should be noted that this type of contract is important and long-term. Neither a medical student nor a community should enter into such an arrangement lightly.

OSMA now is engaged in coordination of this financial aid program with the medical schools at The Ohio State University, the University of Cincinnati, and the College of Ohio at Toledo. OSMA encourages Ohio towns interested in such a financial aid program to contact their county medical societies. These academies also can recommend what a community can reasonably expect in its search for a physician. Through these recommendations, the community can begin its search for a physician



Pictured left to right: Mr. and Mrs. G. B. Newton and OSMA Field Service Director Robert Holcomb.

positively and not waste effort on plans that would not be fruitful.

Medical students interested in this type of financial aid in return for practice in a smaller community should contact the administration of their schools.

McConnelsville began its campaign for a physician by asking advice of surrounding areas and OSMA. Reverend Lowell Petersen chaired a town meeting attended by 300 of McConnelsville's residents. Speakers stressed various plus and minus factors that would affect the town's search. Among these was the necessity of selling the town to the physician's wife as well as the physician

(continued on page 116)

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Doctor, the challenges of pharmaceutical research, and its significant rewards, offer a whole new direction to your medical career.

Working out of our modern Research Center—located in Ann Arbor, Michigan—you will be involved in the excitement of the development of significant new drugs, while enjoying a new-found personal freedom that does not exist in the private practice of medicine.

As a CLINICAL RESEARCH PHYSICIAN at Parke-Davis, you will design, direct and medically evaluate in-depth clinical research studies—studies to prove the safety and efficacy of new drug entities. This challenging work also offers the opportunity to associate with physicians and research scientists in hospitals and clinics who are outstanding in their specialties.

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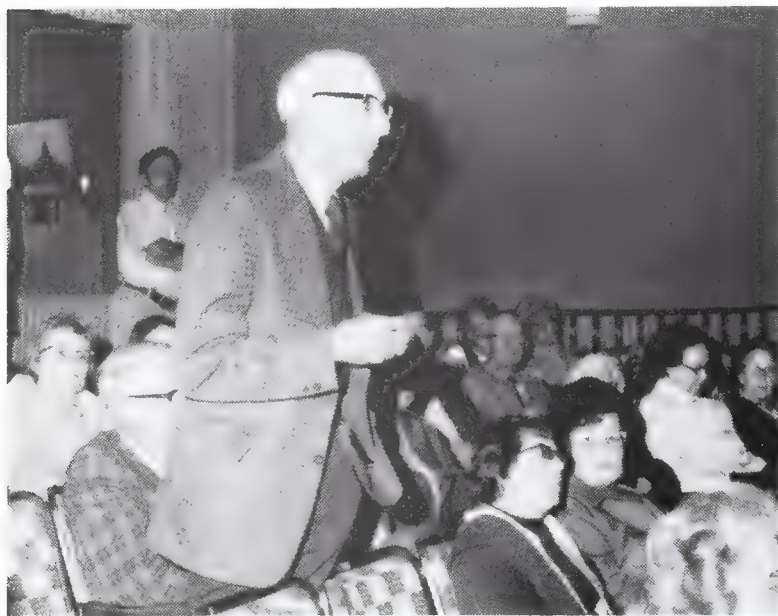
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Physician Shortage *(continued)*

himself. Another point mentioned was distance to the nearest hospital. Physicians who wish to have daily contact with patients in the hospital, to perform surgery, or to deliver babies will find a lengthy drive inconvenient and time-consuming.



A. C. Whitacre, M.D., at the McConnelleville town meeting.

Cedar Springs Trout Club

This exclusive club is now open for limited membership only. Quality limestone stream fly fishing for Brown and Rainbow Trout. Located conveniently in West Central Ohio, near Urbana, 39 miles west of Columbus and 50 miles northeast of Dayton. Excellent access from freeway system and private airstrip. Owned and managed by two professional fisheries biologists. For further information, write:

Cedar Springs Trout Club
c/o T. A. Wheeler
P.O. Box 162
Dublin, Ohio 43017

Another community that sought help from the medical association is Westerville. The new Grant-Otterbein Clinic was desirous of finding a full-time physician. Listing this opening with the OSMA Placement Service, the clinic successfully filled the position.

Marilyn P. Birch, M.D., has spent most of her medical career in Africa. She returns to the U.S. periodically to work and to learn new medical techniques. Upon her return in late 1975, she contacted the OSMA Placement Service and subsequently was interviewed for and accepted the Grant-Otterbein Clinic position.

Towns must evaluate their physician drawing power with the help of their county medical society and OSMA. Then they can determine what type of medical coverage the area can reasonably expect. At that point, positive steps can be taken to secure a physician or other medical personnel.

The physician shortage problem for some areas of Ohio will not disappear overnight, but there are several avenues opening to reduce the problem. One is the National Health Planning and Resources Act which states as one of its priorities the alleviation of shortage and maldistribution of physicians. Another avenue is the family practice residency which has expanded from one year to three. Thus, this program is put on a par with other medical specialties and, therefore, more students should be entering the field and eventually setting up practice in smaller towns. Although financing a medical education and early years in practice has always been a problem, recent encouragement of town-sponsored financial aid programs may make exchange of money-in-aid for service-in-future-years a normal course of events. In addition, emphasis is being given to a community encouraging "hometown boys or girls" to return after completion of medical school. Finally, many retired physicians might be encouraged to practice part-time, especially if there was adequate coverage for referral needs provided by a hub area. These avenues providing physician coverage for small towns will be the topic of a future *Journal* article.



Marilyn P. Birch, M.D.

A regular meeting of the Council of the Ohio State Medical Association was held Saturday and Sunday, December 13 and 14, 1975, at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Mr. D. Mark Mahler, Ohio State University American Medical Student Association Representative; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Holcomb, Freeman, Mrs. Wisse, Mrs. Dodson, Ms. Doll and Mrs. Jacobson, of the OSMA Staff.

Those present Sunday were: All members of the Council; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Freeman and Mrs. Wisse, of the OSMA Staff.

The meeting was called to order by President Lieber.

The minutes of the November 8 and 9, 1975, meeting of the Council were approved.

MEMBERSHIP

The membership report was presented by Mr. Page. Ohio State Medical Association membership showed a net gain of 139 on December 2, as compared to the same date in 1974.

The Council voted to refer to the Committee on Membership and Planning proposals to amend the OSMA Constitution and Bylaws, with regard to the requirements for citizenship and requirements for licensure as prerequisites for OSMA membership.

FISCAL MATTERS

The minutes of a meeting of the Committee on Auditing and Appropriations, held December 12, 1975, were presented by Dr. Thomas.

By official action, the Council approved the 1976 budget presented by the Committee and the schedule of contributions.

The Council voted to commend the Committee for the excellence of its budget presentation and the comprehensive fiscal information provided.

The minutes were approved.

AMERICAN MEDICAL ASSOCIATION

Reports on the 1975 Clinical Session of the American Medical Association, November 28-December 3, in Honolulu, were presented by Drs. Lieber, Henry, Lewis, Thomas, Gaughan, Hogg and Messrs. Pohlman, Page, Edgar and Campbell.

An update on the campaign to elect Dr. John Budd as president-elect of the AMA was presented by Dr. Lewis.

It was reported to the Council that Ohio's policy with regard to the traditional relationship of county societies, state medical associations and the AMA were

presented by Dr. Lieber to the AMA Reference Committee hearing "Report B" of the AMA Council on Long Range Planning and Development.

The Council expressed commendation and appreciation to Dr. Richard L. Meiling for the excellence of his Minority Report on Report B of the AMA Council on Long Range Planning and Development which was presented successfully at the Clinical Session.

Ohio's delegates to the AMA were congratulated on their efforts in support of Dr. Meiling's efforts regarding this issue.

OHIO STATE MEDICAL ASSOCIATION ANNUAL MEETING

Mrs. Dodson reported on the plans for the 1976 meeting of the OSMA.

MAI/PEER REVIEW SYSTEMS

Dr. Henry presented an update report on MAI/Peer Review Systems.

OHIO MEDICAL INDEMNITY, INC.

Mr. Page reported for the liaison committee of OSMA-Ohio Medical Indemnity, Inc.

OHIO FOUNDATION FOR MEDICAL CARE

A report on the Ohio Foundation for Medical Care was presented by Dr. Henry.

COMMITTEE REPORTS COMMITTEE ON MENTAL HEALTH

Minutes of November 16, 1975 meeting were presented by Mr. Clinger.

Leadership Role

The Council approved a committee recommendation "that OSMA take a leadership role in promoting a coalition of mental health advocacy groups, including '648 boards' to more effectively confront and produce solutions to Ohio's pressing mental health problems."

Confidentiality of Records

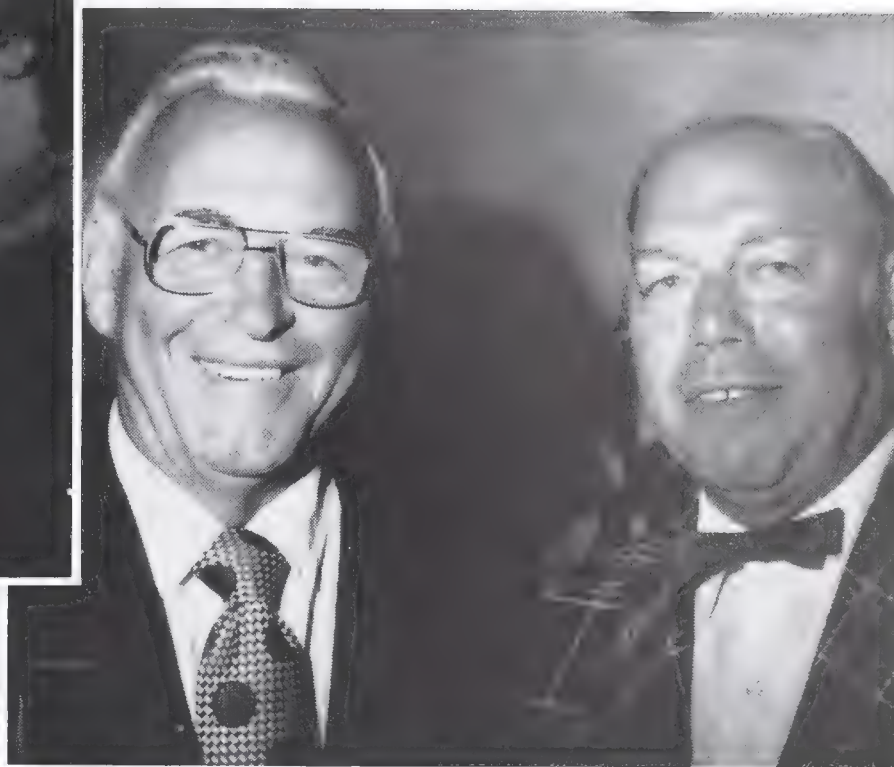
Regarding confidentiality of patient medical records and Sub. H.B. 244 (Ohio General Assembly) on recommendation of the committee, the Council reaffirmed its position as follows:

The OSMA Council considers the preservation of confidentiality between physician and patient as highest priority—and the OSMA Department of State Legislation is requested to consider either new legislation or amendment of current statutes—plus active opposition to anti-confidential legislation. It is further recommended that the OSMA Department of State Legislation work jointly with other interested organizations including the Ohio Psychiatric Association, Ohio Hospital Association, Ohio Psychological Association, and

(continued on page 120)



Pictured left to right beginning at the noon position and moving clockwise: Mrs. Gail Dodson, Herbert Gillen, and Mrs. Katherine Wisse; Maurice Lieber, M.D., and Thomas Morgan, M.D.; Hart Page and Mrs. Page; D. Brent Mulgrew; Mrs. Bricker, Jerry Campbell, Mrs. Campbell, and Steven Bricker; Mrs. Freeman, Douglas Freeman, Mrs. Rebecca (Doll) Hammerschmidt, Mrs. Mulgrew, David Rader, Mrs. Rader, Mrs. Clinger, Robert Clinger, D. Brent Mulgrew, Mrs. Campbell, and Jerry Campbell; Charles Edgar, C. Edward Pichette, M.D., and George Bates, M.D.; David Rader; Robert Rinderknecht, M.D., and Mrs. Rinderknecht; William Wells, M.D., and J. Hutchison Williams, M.D.; James Henry, M.D., Mrs. Clinger, Robert Clinger, and Mrs. Henry.



Ohio Department of Mental Health and Mental Retardation in this major effort to preserve confidentiality.

The OSMA membership shall be informed of the dangers presented by the current language of Sub. H.B. 244 to the confidential relationship between physician and patient.

The Council also **approved** committee recommendations on this matter as follows:

Physicians be urged to contact their legislators in order to call their attention to this situation (regarding confidentiality)—and to urge amendment.

Physicians be urged to encourage their patients and other acquaintances to write individualized letters to their legislators urging amendment.

The Council authorized the officers of OSMA to urge the Governor to veto the bill if present language pertaining to availability of medical records is passed by the Ohio General Assembly.

Other Actions

The Council **approved** Committee suggestions that an OSMA staff member attend meetings of the Ohio Psychiatric and Ohio Psychological Associations and **approved** co-sponsorship with the Ohio Hospital Association of a Psychiatric Audit Team Seminar in Columbus on February 12 and 13, 1976.

The minutes, as a whole, **were approved**.

Mr. Clinger reported on a site visit to the Gallipolis State Institute by Chairman Parker of the Committee on Mental Health, November 12, 1975.

COMMITTEE ON SCIENTIFIC WORK

Minutes of November 16, 1975, were presented by Mrs. Dodson.

The Council recommended that the Committee reconsider November 16, 1975, action, and that a pilot Category I program connected with the OSMA travel program be operated in 1976 to move forward in an active way to upgrade all levels of continuing medical education.

Mrs. Dodson announced a Category I AMA Regional Scientific program to be held in conjunction with the OSMA October 8 and 9, 1977, and plans for a Category I program, to be sponsored by the OSMA committee in Athens, Ohio, during 1976.

1978 Meeting Site

A recommendation of the Committee that the 1978 OSMA Annual Meeting be held in Dayton, resulted in the following Council action:

"That after an on-site visit of Cleveland facilities by a representative of the Committee on Scientific Work, Dr. Gaughan and staff, the officers of the OSMA be authorized to hold a conference call with Dr. Gaughan, Chairman Albers, and a Cleveland representative from the Committee on Scientific Work. The final decision on the city to be chosen for the site was delegated to the OSMA officers."

Category I

Policies on determination of what sponsored or co-sponsored activities of OSMA will receive Category I were adopted by the Council as follows:

- (1) Requests for co-sponsorship must be received a minimum of four months prior to date of activity.
- (2) Category I credit will be available to other organizations (through the OSMA accreditation) only if the Committee on Scientific Work works with the other organizations in planning the CME activity.
- (3) The criteria for Category I shall be the same as that established by the AMA Council on Medical Education.
 1. A planned program with specific educational objectives will be presented.
 2. Syllabi or a brief study outline, references or tests are given to participants.
 3. The program should be evaluated by the sponsor.
 4. Physician participation must be planned, discussion times permitted in the program, or some assessment of needs.
 5. Attendance will be taken (not mandatory in booklet but desirable).
- (4) The objectives for Category I credit shall be the same as that established by the AMA Council on Medical Education.
 1. Changes in the attitude and approach of the learner to the solution of medical problems.
 2. Correction of outdated knowledge.
 3. Explanation of new knowledge in specific areas.
 4. The introduction to and/or mastery of specific skills and techniques.
 5. Alteration in the habits of the learner.

The report of the Committee, as a whole, as amended, **was approved**.

COMMITTEE ON PRISONS AND JAILS

Minutes of the November 19, 1975, meeting of the Committee were presented by Mr. Gillen.

The Council **approved** a recommendation of the Committee that pursuit of a contract with the AMA concerning the development of programs to improve health care in jails be discontinued.

The minutes, as a whole, **were approved**.

COMMITTEE ON LABORATORY MEDICINE

Minutes of a December 6, 1975, meeting of the Committee were presented by Mr. Rader.

(continued on page 124)

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Kaolin	6.0 g.
Pectin	142.8 mg.
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Atropine sulfate	0.0194 mg.
Hyoscine	
hydrobromide	0.0065 mg.
Powdered opium, USP	24.0 mg.
(equivalent to paregoric 6 ml.)	
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Each 5 ml teaspoonful contains:

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Decongests nasal passages and sinus openings as it helps relieve coughs

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Guaifenesin, NF. 100 mg
Pseudoephedrine** Hydrochloride, NF. 30 mg
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**Formerly contained Phenylephrine Hydrochloride 10 mg

Decongestant action helps control cough and clear stuffy nose and sinuses. Non narcotic.

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Guaifenesin, NF. 50 mg
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A. H. Robins Company, Richmond, Va. 23220 **A-H ROBINS**

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives... accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The William Mason (1856)

The Council **approved** a committee recommendation that the Department of State Legislation work with the Ohio Department of Health to obtain amendments to H.B. 872 (Ohio General Assembly) having to do with registration of clinical laboratories and laboratory personnel, to provide greater clarity, standardize definitions and greater detail concerning the degree of independence allowed laboratory personnel.

Also **approved** was a recommendation that the OSMA Department of Federal Legislation be instructed to set up a meeting with Senator Robert A. Taft and Ohio pathologists with regard to the "Clinical Laboratories Improvement Act of 1975."

The minutes were accepted.

COUNCIL FEE REVIEW COMMITTEE

The minutes of the December 12, 1975, meeting of the Committee were presented by Dr. Rinderknecht and **were approved**. Dr. Pichette abstained on all votes in connection with Council consideration of these minutes.

COUNCILOR REPORTS

The Councilors reported on various activities in their respective districts and discussed grievance and professional liability matters therein.

FEDERAL LEGISLATION

Mr. Edgar reported on the status of several legislative proposals pending in Congress.

Consideration of a proposed Washington Visitation, April 13, 1975, was deferred until next meeting of the Council.

STATE LEGISLATION

Mr. Rader presented information on H.B. 533 (Ohio General Assembly), with regard to licensing of county nursing homes. The Council voted **support** of the legislation.

The Council received a document dated November 14, 1975, filed with Dr. Gaughan by Edward G. Kilroy, M.D., Cleveland, proposing an amendment with regard to "definition of death."

Messrs. Rader and Mulgrew conducted a detailed discussion of H.B. 682, its enforcement and implementation, and proposals for additional legislation with regard to improvement of the professional liability situation in Ohio.

CONSTITUTION AND BYLAWS

Amendments to the Constitution and Bylaws of the following county medical societies **were approved** by official action:

Auglaize, Warren, Brown, Clark (based on the notification of the acceptance of changes previously suggested by the Council).

LEGAL COUNSEL REPORT

Mr. Pohlman reported on a meeting of medical society legal counsel during the AMA Clinical Session. He stated that arbitration, both the mandatory, non-binding and voluntary, binding types, were discussed and felt to be the "principal short term solution to the professional liability insurance problem" and stated that the Association's program is in accord with the current thinking among the medical society legal counsel group.

HOSPITAL REQUIREMENT FOR PHYSICIANS' INSURANCE

The Council voted opposition to compulsory professional liability insurance as a condition for medical staff membership.

It was the sense of the Council that the following subjects be discussed at the next Joint Meeting of Officers of OSMA, Ohio Hospital Association and the Ohio Osteopathic Association of Physicians and Surgeons: self-insurance by hospitals; a requirement that



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PHYSICIAN AND HOSPITAL EQUIPMENT

hospitals submit to medical staffs evidence of hospital liability coverage; and requirements that medical staffs submit to hospitals evidence of professional liability coverage as a condition of staff membership.

MULTIPHASIC HEALTH TESTING

Mr. Pohlman reported that the advice of George Meisel, Esq., of Cleveland, to the Cleveland Academy of Medicine, in a communication dated September 30, 1975, and concerning Multiphasic Health Testing, is in accordance with OSMA policy.

It was the expression of the Council that OSMA members be alerted to this matter, and that the problem be discussed with the Ohio State Medical Board.

FIELD SERVICE REPORT

Mr. Holcomb reported on the work of the Field Service, subsequent to the last meeting of the Council, and reviewed plans for 1976, including meetings with Ohio county medical society executives.

Mr. Freeman presented to the Council advance copies of the 1976 Handbook for County Medical Society

Officers. It was announced that the book will be hand-carried by the field staff to county society presidents and that it will be reviewed with these officers in a personal conference.

The Council voted to commend Mr. Freeman on the excellence of this project.

OHIO STATE MEDICAL JOURNAL

Mrs. Jacobson reported on plans for continued improvement of *The Ohio State Medical Journal*. New features were discussed and Councilors were asked to encourage submission of clinical papers by members in their districts.

ROBERT N. SMITH RECOMMENDED

Past President Robert N. Smith, who is Chairman of the Medical Advisory Committee to the State Health Agency in Ohio, was recommended for appointment to the National Council on Health Planning and Development, by action of the Council.

ATTEST: Hart F. Page
Executive Director

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Area Code 614 - 885-5381

George T. Harding, M.D.
Medical Director

Donald L. Hanson
Administrator

The Medical Educators' Association with participants from the OSMA Commission on Medical Education will present a program entitled, "Continuing Medical Education in Ohio—Implementation of H.B. 682." This conference will be held on March 13, 1976, at Marriott Inn, 4277 West 150th Street, Cleveland, Ohio.

This one-day conference will present information on the new regulations for physician relicensure. Also included will be a workshop on procedures hospitals must follow to qualify for accreditation of their CME program plans.

For program information write: Medical Educators' Association, 5211 Mahoning Avenue, Suite 310, Youngstown, Ohio 44515.

Ophthalmology Symposium; March 1-2; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by the Ohio State University Center for Continuing Medical Education, 320 W. 10th Ave., Columbus 43210; \$100 registration fee.

Advances in Urology; March 3-4; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; \$80 registration fee; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Investigation for or Treatment of Renal Hypertension; March 9; sponsored by the Fort Steuben Academy of Medicine, 525 N. 4th St., Steubenville 43952.

Medical Progress and Its Relationship to Dentistry; March 10-11; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; \$50 registration fee; 1 credit toward AMA Physician's Recognition Award.

VA Hospital Annual Cincinnati VA Hospital Medical Symposium; March 11; VA Hospital, Vine St., Cincinnati, contact University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

The Myelomeningocele Patient—A Multidisciplinary Approach; March 11-13; University of Cincinnati Medical Center; contact the Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

Gynecologic Breast Problems, Surgical Physiology; March 17; Park Plaza, Cleveland; sponsored by the Cleveland Society of Obstetricians and Gynecologists.

Annual Esophagus Symposium; March 18-19; Jewish Hospital, Burnet Ave., Cincinnati, contact University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

Auxiliary

MRS. S. L. MELTZER, Communications Chairman

The latter part of 1975 witnessed a new and most effective "reaching out" to the counties by the National Auxiliary. For the first time, county presidents-elect were invited to an Auxiliary Leadership Confluence. This three-day meeting of state presidents and presidents-elect, the National Board of Directors, and members of the national committees was held in Chicago. It proved to be the largest leadership meeting of its kind in auxiliary history. Seminar topics included safety on the streets, child abuse, the impaired physician, and rape.

Catch Up Time

So many county auxiliaries doing so many outstanding activities . . . there never seems to be enough space to record it all! **Trumbull County's** Mobile Meals program celebrated its fifth anniversary a couple of months ago. The volunteer program is currently delivering hot, nourishing meals to nearly 100 shut-ins. The low cost service numbers over 300 dedicated volunteers. Under the direction of Mrs. John Schlecht and Mrs. C. M. Venetta, the auxiliary inaugurated its Mobile Meals program on November 23, 1970. The service soon expanded to include a call for additional volunteers from the community and extension of the meal preparation phase of the program to St. Joseph's Riverside Hospital. Another food preparation base was opened at Warren General Hospital in February 1975. Mobile Meals now serves subscribers in Warren, Niles, Newton Falls, Cham-

pion, and Howland Townships. The Trumbull Auxiliary maintains its support of the program through financial contribution as well as outstanding volunteer assistance.

The Child Health Association recently expressed its gratitude to the **Hamilton County** group for funds to enlarge the Health Film Library. Films purchased included "Teeth Are for Life" and "The Heart and Its Work." Hamilton's "Apple Tree" has a new toy shed, a much needed addition to the playground. It will house bikes and other wheeled toys so that the staff, with the help of the children, can get them in and out easily. The "Apple Tree" is a non-profit, fully licensed day care center for three-to-five-year old children of women in medical fields. It was established in 1964 and is administered by the Hamilton County Auxiliary.

The Home and Garden Tour sponsored by the **Franklin County** Auxiliary a few months ago benefited the group's Nurses' Scholarship project. Franklin also hosted a Christmas party for patients at Columbus State Hospital.

Jefferson County members held a work session on the "johnny coats" project in December. They removed cuffs, collars, and buttons from used shirts and transformed them into hospital gowns for the International Health Program.

An Important Reminder

March 9 and 10: "Day at the Legislature." If you want to be part of it, make that reservation now!

Art Show Planned

FOR 1976 OSMA ANNUAL MEETING

Space will be provided at the 1976 Annual Meeting of the Ohio State Medical Association, May 10, 11 and 12, at the Cincinnati Convention Center for a Physician's Art Show. The Art Show will be under the direction of Harry H. Fox, M.D., local Cincinnati physician as well as, Chairman of the Art and Culture Committee of the Medi-Club of the Academy of Medicine of Cincinnati. Dr. Fox directed the outstanding 1972 Art Show held in Cincinnati.

Members of the OSMA, their wives (or husbands), who are interested in exhibiting art pieces (they personally have created) or who require information regarding the exhibit, should fill out the application included below without delay.

It will be the responsibility of each exhibitor to see that his work gets to the Cincinnati Exposition Center. Final arrangements will be taken care of by a committee.

The OSMA will provide suitable display facilities, but each physician and/or wife is responsible for transportation costs and any other such expense involved in entering his or her exhibit. Art show security will be on duty.

Exhibitors will be limited to two art pieces per category.

An Art Award Committee will judge the exhibit competitively.

We solicit your exhibits to make the 1976 Art Show an outstanding success.

Application for Space in Art Show Exhibit

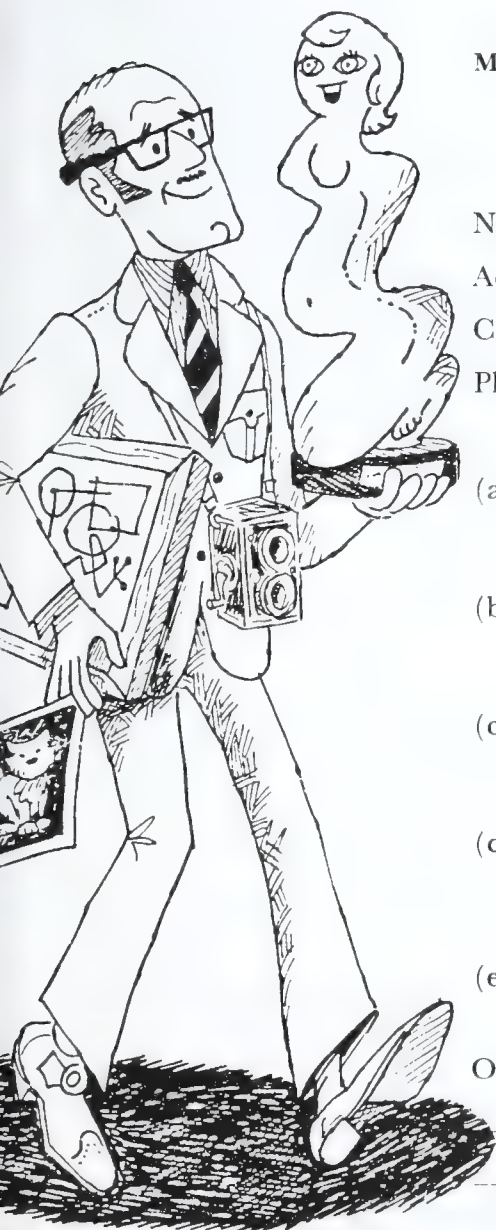
Mail to: Harry H. Fox, M.D., Chairman
1976 OSMA Art Show Committee
19 West Eighth
368 Doctors Building
Cincinnati, Ohio 45202

Name _____
Address _____
City _____ Zip Code _____
Phone No. _____

	Title	Dimensions	Value*
(a) Paintings (watercolor)	1. _____	_____	_____
	2. _____	_____	_____
(b) Paintings (oil or acrylics)	1. _____	_____	_____
	2. _____	_____	_____
(c) Sculpture	1. _____	_____	_____
	2. _____	_____	_____
(d) Photo-Arts (preferably mounted to hang)	1. _____	_____	_____
	2. _____	_____	_____
(e) Crafts (variable)	1. _____	_____	_____
	2. _____	_____	_____

Other information (which you believe will be helpful to the Art Show Committee).

(*Please include a fair market value for insurance)



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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

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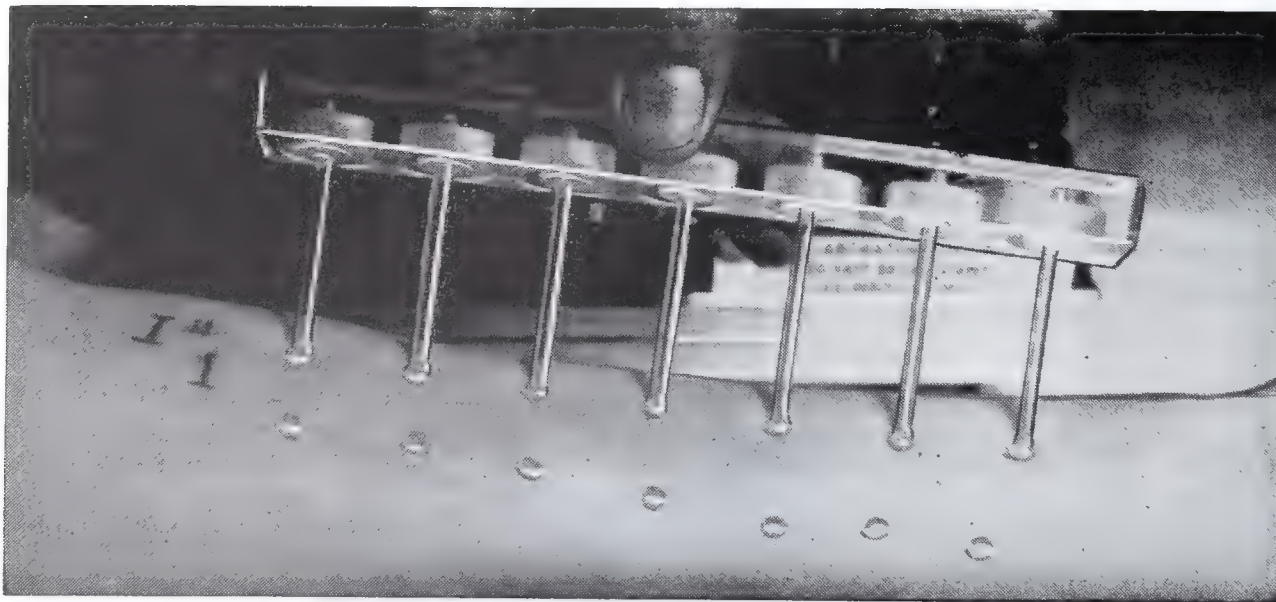
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Legislative Update

David L. Rader, OSMA Associate Executive Director

House Committee Tightens Insurance Rules

The House Insurance, Utilities and Financial Institutions Committee recommended for passage **H.B. 1267**, Cook (D-Cuyahoga Falls), to broaden the authority of the Ohio Superintendent of Insurance. Under the bill, non-assessable mutual insurance companies would be required to have \$2.5 million capitalization for organizational purposes, reciprocals would be required to have \$4 million, and the guaranty fund (which protects insurance companies in case of insolvency) would not be available to any existing professional liability reciprocals. The Ohio Department of Insurance is seeking this bill because a number of insurance companies in Ohio and other states have been having financial problems as a result of insufficient original capitalization. The bill, which has a great deal of support in the Legislature, will be up for House floor debate very quickly.

Mental Health Bill Reported Favorably

The Economic Affairs and Federal Relations Committee of the Ohio House recommended for passage **H.B. 1215**, Jaskulski (D-Garfield Heights), to make major changes in the system of operating Ohio's mental health centers. Among other things, the bill would take physicians off civil service roles thus enabling the Director of Mental Health to deal more effectively with problem areas within the institutions and would require that the institutions cooperate with medical schools in establishing residency programs in psychiatry. The bill has the support of the Ohio Department of Mental Health, and a number of changes requested by the Department were included prior to the bill's being recommended for passage.

Senate Committee Debates Physician Jury Exemption

Am. H.B. 136, Lehman (D-Cleveland), received a second hearing in the Senate Judiciary Committee. This bill would make physicians, attorneys, school teachers, dentists, clergy, and other, liable for jury duty. These individuals are now exempt from such duty. An OSMA spokesman was the only witness to testify in opposition to the bill stating that physicians need to be spending their time with patients, not waiting long hours to be called for jury selection. He suggested that perhaps physicians who would like to be eligible for jury duty could voluntarily place their names on the jury roles.

Senator Robert O'Shaughnessy (D-Columbus) supported a concept which has been proposed by the OSMA to exempt from jury duty physicians who are in the active clinical practice of medicine. Language to this effect is being drafted now for his consideration and also for the consideration of the full Judiciary Committee.

Pap Test Mandation Bill Recommended

The Ohio Nurses Association (ONA) was successful in getting the House Human Resources Committee to favorably recommend **H.B. 1000**, Panehal (D-Cleveland), which would require hospitals in Ohio to offer uterine cytologic examinations to female in-patients over 20 years of age unless the patient or the patient's physician declines the test. The OSMA (which has a position in favor of such tests) testified in opposition to this bill because Ohio's physicians do not believe that tests such as this should be mandated by state government. However, the ONA testified on a number of occasions that this was an "easy, simple test" and indicated that it could be handled by nurses within the hospital setting. The bill does not have any appropriation attached to it for payment for these tests nor was any indication given at the hearings on what increase in total health care costs a test of this type might bring. The OSMA will now begin work with members of the full House concerning this problem.

Emergency Services Bill Passes House

The Ohio House overwhelmingly voted support of Sub. H.B. 832, Colonna (D-Brook Park), to redesign the definitions of emergency medical technicians and paramedics in Ohio. The redrafted bill had a great deal of input from the OSMA including a passage which restricts the liability of physicians acting in concert with ambulance personnel utilizing telemetry procedures. The bill now goes to the Senate where hearings will be held shortly.

"Patient's Bill of Rights" Gets First Hearing

The Senate Judiciary Committee held a hearing on S.B. 363, Headley (D-Barberton), the "patient's bill of rights." There was one witness who testified that he had an extremely bad experience when his wife was hospitalized and for that reason he felt the necessity for a state law to delineate clearly what the rights are of a patient in a hospital. OSMA representatives have not yet had an opportunity to testify in opposition to this bill but have contacted many members of the Senate expressing grave doubts about many portions of this legislation which would place extreme burdens upon both hospitals and physicians and which might, in effect, lower the quality of care rendered in Ohio's health institutions. Senator Headley, chief sponsor of the bill, is also the Chairman of the Senate Judiciary Committee.

Occupational Therapy Bill Recommended

Ohio's occupational therapists will get a new licensing board under the provisions of H.B. 1227, Hartley (D-Springfield), which was recommended favorably by the House Human Resources Committee. Occupational therapists are currently not licensed under any state agency and this bill would license them as well as occupational therapy assistants. Testimony given by proponents indicated that there are approximately 700 occupational therapists in Ohio and that without some form of state license, quality cannot be assured in the area of occupational therapy. They also stated that some patients cannot receive adequate O.T. because third party payments often cannot be made to nonlicensed ancillary personnel. The bill will receive floor debate shortly.

The Journal to Use United Media as National Advertising Rep.

Beginning with the April issue, *The Ohio State Medical Journal* will use United Media Associates, Inc. as its national advertising representative. United Media is located at 16 Bruce Park Avenue, Greenwich, Connecticut 06830. The telephone number is 203/661-9702. Firms interested in placing advertising in *The Journal* should contact either United Media or Linda Jacobson, *The Journal*, 600 South High Street, Columbus, Ohio 43215, telephone 614/228-6971.

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Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

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Family Practice Scholarship Applications Being Accepted

Applications for the Thomas E. Rardin Family Practice Scholarships sponsored by OSMA are now being received, marking the 28th year of existence for the scholarships.

"The two, \$2,000 scholarships are awarded annually for the purpose of stimulating interest among medical students in practicing family medicine in Ohio," said Maurice F. Lieber, M.D., OSMA President. Dr. Lieber added that family physicians are needed in many rural and inner-city areas of Ohio.

The scholarships are named in honor of the late Thomas E. Rardin, Sr., M.D., of Columbus, who helped found the American Board of Family Practice and establish the Ohio Academy of Family Physicians. Dr. Rardin died in March 1972, after 40 years of family practice.

Candidates are required to be Ohio residents, to have completed their premedical education, and to have been accepted by an approved U.S. medical school. Application must be made in the year of entering medical school but prior to beginning medical studies.

Candidates are judged on the basis of interest in family practice, leadership, interest in community activities and organizations, intelligence, maturity, scholastic ability, and need.

Administered by the OSMA Family Practice Scholarship Subcommittee, the program pays each recipient from a four-year medical school \$500 annually. Payment dates are arranged with students enrolled in three-year medical schools. The award is paid directly to the winners.

Application forms may be obtained from the Family Practice Scholarship Subcommittee, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215. Completed applications must be in the OSMA offices no later than May 1, 1976.

Approximately 15 candidates will be selected for final judging from among those who meet the May 1 application deadline. Final judging will take place on Wednesday, June 16, at OSMA's Columbus headquarters. Attendance will be mandatory for the finalists. Finalists will be notified no later than May 24.

Ohio State Medical Student Awarded International College Of Surgeons Scholarship

The International College of Surgeons granted a \$1,000 Undergraduate Scholarship to Timothy Quinn, a senior medical student at The Ohio State University College of Medicine. This award will provide for a two-month study program in orthopedic surgery at the North-

wick Park Hospital, London, England.

Eduard Eichner, M.D., Associate Visiting Gynecologist-Obstetrician at Mount Sinai Hospital, Cleveland, and Associate Clinical Professor at Case Western Reserve University, presented the award. Recipients are selected based on achievement, grades, and recommendations.

MAI Sponsors Symposium

The Medical Advances Institute (MAI) announces a day-long symposium entitled "Legal Implications of Peer Review Programs" to be held March 31, 1976, at the Hilton Inn North in Worthington, Ohio. The sponsors of the event are, in addition to MAI, the Ohio Hospital Association, the Ohio Osteopathic Association, the OSMA, and the Graduate Program in Hospital and Health Services Administration of The Ohio State University.

Robert Clark, M.D., Chairman of the Board of Trustees of MAI and President and Medical Director of Region VI Peer Review Corporation, will preside over the program.

The symposium can accommodate 200 participants. There will be a nominal tuition and luncheon fee. For further information contact Mr. Christopher Fulton, Director of Field Service, MAI, 1225 Dublin Road, Columbus 43215, (telephone: 614/481-8871), or your county medical society.

Misdiagnosis Top Malpractice Claim

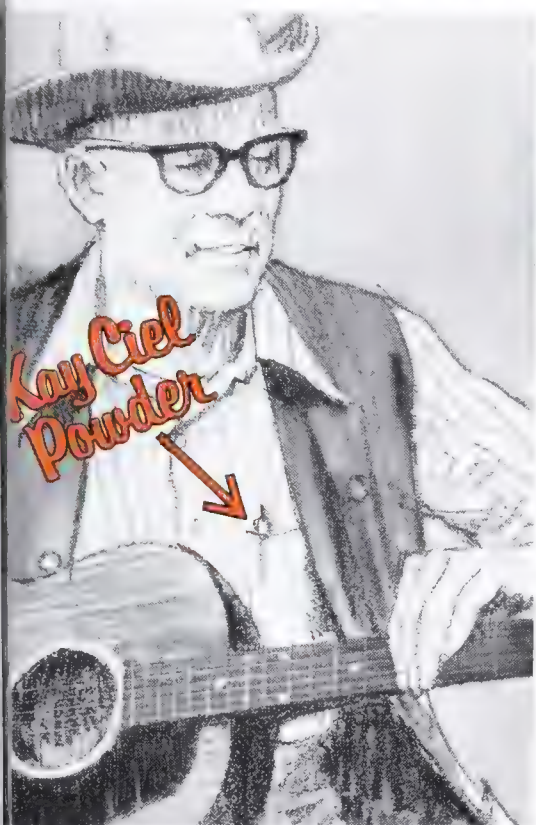
Misdiagnosis is the most often cited single injury event in malpractice suits against physicians, according to a December 15 report of the National Association of Insurance Commissioners. The report is the first nationwide compilation of information from insurance companies. The survey shows the majority of suits claim injuries above and beyond "bad results" in which treatment does not meet the patient's expectations.

A trend toward multiple defendants is noted with an average of 1.43 defendants per claim. Malpractice claims against physicians and surgeons make up 57 percent of all claims by count and 65 percent by amount. Hospitals are defendants in 38 percent of claims by number and 32 percent by amount.

Columbus Hospital Receives Ross Laboratories' Donation

Ross Laboratories of Columbus has made another \$10,000 donation to help finance construction of the main building at Children's Hospital, Columbus. This donation brings the company's total support of the building program to \$60,000.

(continued on page 138)



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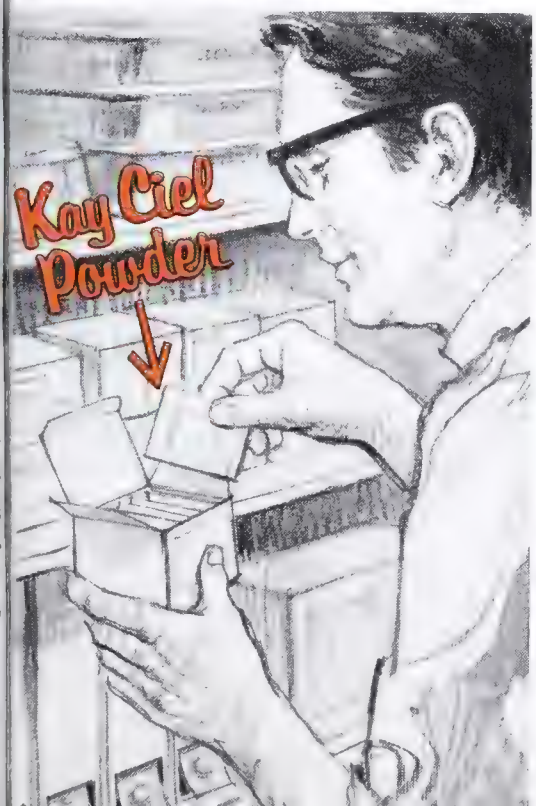
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Is Your Doctor Reports Reaching the Waiting Room?

The March issue of *Your Doctor Reports* contains interesting and practical health information for patients. Among the articles appearing in March are ones covering why a patient should follow his physician's prescription drug instructions, precautions for sunlamp use, and the importance of Ohio's medical microwave in linking teaching hospitals with rural areas of the state. Patients will also read about the duties of each person in the operating room.

Be sure to place the March issue of *Your Doctor Reports* in the waiting room.

New Name for OSMA Committee on Maternal Health

The Ohio State Medical Association Committee on Maternal Health has altered its name to the Committee on Maternal and Neonatal Health. The Committee on Maternal Health, whose first meeting was held in January 1954, has expanded from 9 to 21 members. Currently,

there are plans to add a pediatrician and neonatologist to the committee.

The major function of the committee has been to make a study of maternal mortalities in the State of Ohio. Additionally, *Guiding Principles for Obstetric Care* have been developed by the Committee on Maternal Health as a part of its study and evaluation of maternal deaths in Ohio. These principles have been used extensively over the years in Ohio and as a model in other states.

Annual reports of the Committee's findings have been published in *The Ohio State Medical Journal* with reprints sent to many parts of the world. Excellent liaison with the Ohio Department of Health and representatives of the county medical societies has evolved due to this study of nearly 1,800 cases in 21 years. The Committee has also provided many scientific articles and exhibits and has served in an advisory capacity concerning maternal health problems.

Along with the Committee's name change are plans to expand the perimeter of the Committee to include the health of the newborn from birth to 28 days of age.

Anthony Ruppertsberg, Jr., M.D., of Columbus, was appointed Chairman of the original Committee and has served in that capacity ever since.

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Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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MRS. S. L. MELTZER, Communications Chairman

I dare to paraphrase Shelley! "If March comes, can May (and convention) be far behind?" It just does not seem possible that the 1975-1976 Auxiliary year is fast approaching its annual state meeting. Here is a quick preview to orient the counties. The dates are May 10, 11, and 12. The place is the Terrace Hilton Hotel in Cincinnati. Mrs. Chester Young, Second Vice-President of the AMA Auxiliary, will be National's representative. She will address the House of Delegates and install the 1976-1977 officers. Mrs. Robert E. Krone, State President, will preside.

There will be state committee meetings and the preconvention board meeting on Monday, the 10th. The general membership is invited to a special Monday afternoon session with OSMA that will feature a program on rape. Mayor Bobbie Sterne, wife of Eugene H. Sterne, Jr., M.D., and the first woman mayor of Cincinnati, will officially welcome auxiliaries to the First Business Session of the House of Delegates on Tuesday morning, May 11. Let it be noted that Bobbie Sterne is an active member of the Hamilton County Auxiliary, and it is with pride that we salute her!

Maurice F. Lieber, M.D., OSMA President, will address the House of Delegates at its first session.

"What's Cooking?" is the provocative designation for the annual County Reports' Session on Tuesday, the 11th. Tuesday's social events include two joint functions with OSMA: the annual OMPAC luncheon at Convention Center and an evening at the beautiful Beverly Hills Supper Club "across the river."

Wednesday morning's Breakfast Session will provide a look to the future. State President-Elect Mrs. William Myers and her county presidents-elect will be zeroing in on plans for 1976-1977. As was noted in this column last month, there has been a new emphasis on Auxiliary leadership this year that has focused on the county president-elect as never before. AMA-ERF and membership awards will be presented at the convention's Second Business Session Wednesday morning.

Installation of the 1976-1977 state officers will be a special feature of the Wednesday noon luncheon. George Bates, M.D., OSMA President-Elect, will address the membership on the Medical Association's program for the coming year.

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EACH ANDROID-G TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg
Methyltestosterone	1.25 mg
L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets Rx only.

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COLLEAGUES IN THE NEWS . . .

Robert M. Zollinger, M.D. Nominated for AMA Sheen Award

ROBERT ZOLLINGER, M.D., has been nominated by OSMA and the Academy of Medicine of Columbus and Franklin County for the Dr. Rodman E. Sheen and Thomas G. Sheen Award. First presented in 1968, the Sheen Award has become a symbol for outstanding achievement in medicine by a Doctor of Medicine.

Consisting of a \$10,000 cash prize and a commemorative plaque, the Sheen Award is bestowed annually at the Convention of the AMA to an American physician (or physicians) in recognition of his outstanding contribution to medicine.

In nominating Dr. Zollinger, OSMA and the Academy of Medicine of Columbus and Franklin County stated, Dr. Zollinger should be considered "because he has made outstanding contributions to his students, community, country, the practice of medicine, and is an ambassador of goodwill throughout the world."

Dr. Zollinger, who graduated from The Ohio State University College of Medicine, served as Chairman of the Department of Surgery there from 1947 through 1974. He has authored or coauthored more than 260 publications; his most fruitful research investigation has been the relationship between the non-beta islet cell tumors of the pancreas and diseases of the gastro-intestinal tract: the Zollinger-Ellison Syndrome. In 1963, the Board of Trustees of The Ohio State University established the first named chair of the university in Dr. Zollinger's honor: the Robert M. Zollinger Chair of Surgery.

SAMUEL L. ASPIS, M.D., Director of Wade Park and Brecksville Veterans Administration Hospital, has been named outstanding veteran of the year by the Joint Veteran's Commission of Cuyahoga County.

Dr. Aspis was a medical officer in the Army from 1942 to 1946. He was director of the Wade Park Veterans Administration Hospital before it was consolidated with the hospital in Brecksville.

J. RICHARD BRIGGS, M.D., Columbus, has been elected president of the medical staff of Grant Hospital. Newly-elected chairmen are **ALBERT HART, M.D.**, Department of Obstetrics and Gynecology; **JAMES S. McCAUGHAN, M.D.**, Department of Surgery; and **T. WILLIAM EVANS, M.D.**, Department of Emergency Medicine.

WALTER A. DANIEL, M.D., has been installed as president of the medical staff of Tiffin Mercy Hospital. Other medical staff officers for 1976 include **ILHAN ALPAY, M.D.**, vice-president; and **ARMANDO GARZA, M.D.**, secretary-treasurer.

FREDERICK DAVIDORF, M.D., of Gahanna, will chair the 1976 statewide medical Advisory Committee, of the Ohio Society for the Prevention of Blindness. Dr. Davidorf is Director of the Retina Unit, Department of Ophthalmology, The Ohio State University College of Medicine.

Serving as vice-chairman will be **FRANK J. WEINSTOCK, M.D.**, of Canton. Dr. Weinstock, who chaired the committee in 1975, is Clinical Assistant Professor, Department of Ophthalmology, The Ohio State University College of Medicine.

Drs. Davidorf and Weinstock will also serve as voting members of the National Society for the Prevention of Blindness, the second oldest voluntary health agency in the country, having been founded in 1908.

John Ackerman, M.D., Ohio Director of Health, has announced the appointment of nine new members to the Ohio Crippled Children Services Medical Committee. The members, who receive no compensation, will serve terms that expire on December 31 of the years indicated. The new appointees are **ALFRED HICKS, II, M.D.**, Dayton (1976); **NICHOLAS J. GIANNISTRAS, M.D.**, Cincinnati (1977); **JAMES M. ANDREW, M.D.**, Columbus; **H. G. BIRCK, M.D.**, Columbus; **CHARLES H. HERNDON, M.D.**, Cleveland; **C. W. HULLINGER, M.D.**, Springfield; **MARK RAYPORT, M.D.**, Toledo; **MARGARET G. ROBINSON, M.D.**, Toledo; and **RAYMOND S. ROSEDALE, JR., M.D.**, Canton (1978).

Centerville physician **HAROLD G. KELSO, M.D.**, has been named chief of the medical staff at Kettering Medical Center. Dr. Kelso has served as Vice-Mayor of Centerville and was recently board chairman for Centerville public schools.

MARK McGOVERN, M.D., has been named Medical Director of the Ambulatory Services Department at Children's Hospital Medical Center, Cincinnati. As Medical Director of Ambulatory Services, Dr. McGovern is responsible for the emergency department, outpatient surgery, and other outpatient services. He had served as Assistant Medical Director of the department since 1973.

WILLIAM P. MAHONEY, M.D., is the new president of the medical staff at Southwest General Hospital, Strongsville. Vice-president of staff is **G. H. DERIAN, M.D.**, who was reelected to that post, as was the secretary-treasurer **W. R. FUNK, M.D.**

Department head and section chief physicians named for 1976 include: **J. D. WISMAR, M.D.**, medicine; **H. DEHN, M.D.**, pediatrics; **W. R. FUNK, M.D.**,

surgery; **G. H. DERIAN, M.D.**, urology; **W. E. HEYSE, M.D.**, orthopedics and physical medicine; **B. B. BRAUSTON, M.D.**, ophthalmology; **J. Y. KALUCIS, M.D.**, otolaryngology; **W. M. HOGARTY, M.D.**, neurosurgery; **C. S. LI, M.D.**, plastic surgery; **R. C. SINGERMAN, M.D.**, thoracic and cardiovascular surgery; **A. G. HILADO, M.D.**, anesthesiology; **R. E. MAYER, M.D.**, obstetrics and gynecology; **W. H. BOND, M.D.**, general practice; **R. W. AUBREY, M.D.**, pathology; and **K. R. IRISH, M.D.**, radiology.

E. DALE MATTMILLER, M.D., Acting Vice-President for Academic Services and Coordinator of Unified Health Services at Ohio University, has been named Professor of Family Medicine for the university's new College of Osteopathic Medicine.

Dr. Mattmiller supervises the Ohio University Hudson Health Center, is a physician for university athletic teams, and is an associate professor of health, physical education, and recreation. He is also a past-president of the Athens County Medical Society.

SANFORD PRESS, M.D., of Steubenville, a family practitioner, has been installed as President of the Ohio State Medical Board. A native of Cleveland, Dr. Press has practiced medicine in Steubenville for the past 35 years. He is on the staff of St. John Medical Center and Ohio Valley Hospital, where he served on the Board of Directors from 1971 to 1973, was president of the staff during 1972, and was medical director in charge of the intern program until 1973.

Dr. Press lists among his many professional memberships: the American Academy of Family Practice; the OSMA, where he served on the Council from 1966 to 1972; the Ohio Academy of Family Practice, where he was Speaker of the House and Delegate from 1963 to 1967; the Fort Steuben Academy of Medicine, where he served as president and is serving as secretary-treasurer; and the International College of Surgeons, U.S. Section.

WILLIAM R. SCHULTZ, M.D., of Wooster is presently serving a three-year term as a member of the House of Delegates of the American Hospital Association. Dr. Schultz represents the country of Canada and the states of Ohio, Wisconsin, Illinois, Indiana, and Michigan in the House of Delegates.

Dr. Schultz is a past-president of the OSMA. He is presently a member of the Wooster Hospital Board of Governors and of the Board of Trustees of the Ohio Hospital Association.

WILLIAM V. SHARP, M.D., Director of the Vascular Research Laboratory at Akron City Hospital, has been awarded a Heart Association research grant of \$16,665.

JOHN P. SHULTZ, M.D., has been elected president of the Children's Hospital medical staff for 1976. Dr. Shultz, who joined the Columbus hospital staff in 1965, is Clinical Associate Professor of Pediatrics at The Ohio State University College of Medicine.

Other officers are **JUAN F. SOTOS, M.D.**, vice-president; and **JAMES W. KILMAN, M.D.**, secretary-treasurer. Dr. Sotos is John W. Champion Professor of Pediatrics at Children's Hospital, and Dr. Kilman is Professor of Surgery at The Ohio State University College of Medicine.

FRANKLIN SIMECEK, M.D., has been appointed to his second term as President of the Medical Staff of Cleveland's St. Alexis Hospital. Dr. Simecek, now in his 25th year on the hospital staff, has served as a member of the trauma and disaster committees of the Cleveland Academy of Medicine and as director of the Department of Surgery at St. Alexis in 1964 and 1965. He is the president of the Northeastern Ohio Council of Medical Staffs and is on the board of directors of the Cleveland Academy of Medicine.

(continued on page 151)



The Ohio State Medical Board: Seated (left to right): John D. Brumbaugh, M.D., Akron; Anthony Ruppertsberg, Jr., M.D., Columbus; Sanford Press, M.D., Steubenville; and Henry A. Crawford, M.D., Cleveland. Standing (left to right): Evelyn Cover, D.O., Columbus; Peter Lancione, M.D., Bellaire; Mr. Walter Paulo, Canfield; Henry G. Cramblett, M.D., Columbus; Richard Jacobs, D.P.M., Bellaire; and Roland A. Gandy, Jr., M.D., Toledo.

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3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

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Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

OSMA New Members

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during January 1976. List shows name of physician, county, and city in which he is practicing or in which he is taking postgraduate work.

Allen (Lima) Tae-Ahn Thomas Lee Tson-Kuang Wu	Lorain (Amherst) Demosthenes R. Sison, Jr.
Athens Ernesto D. Cordova Nelsonville Evan W. Dixon Athens	Lucas (Toledo) Shaded B. Ahmed John P. Anders Soterios J. Kakissis Martha V. Kleinberg Rajni B. Sharma Isabel Y. Sim Thomas G. Welch Anoar Zacharias
Clinton (New Vienna) Karlanders Otterland	Madison (Mechanicsburg) William B. Saxbe, Jr.
Cuyahoga (Cleveland) Linnea J. Jones Mortimer B. Lipsett Charles W. Williams Ralph B. Woolf	Marion (Marion) Ali R. Shreim
Franklin (Columbus) James H. Rutherford	Montgomery (Dayton) Alan J. LaClave B. S. Paraswanath Terence P. Torbeck
Greene (Xenia) Fang Chi Huang John W. LaVoo	Muskingum (Zanesville) Lowell H. Body, II
Guernsey (Cambridge) Bilimagga V. Chendraj Billimagga Rangaswamy	Sandusky (Fremont) Beruti I. Beruti
Henry (Napoleon) Karim N. Zafar	Seneca (Tiffin) Neung Soo Kim
Hancock (Findlay) Ireneo P. Echavarre Alan T. Tong Joseph A. Weingates, III Emil C. Ziegler	Shelby (Sidney) Gary C. Harris
Lake (Mentor) Mohamed A. Atassi	Stark (Canton except where noted) Donald M. Benson Robert E. Carter, Jr. Robert C. Reed (Alliance)
Licking (Newark) Ramanadham Kilaru	Wood (Bowling Green) Rogelio A. Sanchez

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obituaries

Richard Birnbaum, M.D., Akron; University of Wisconsin Medical School, Madison, 1929; age 73; died December 23; member OSMA and AMA.

Luther O. Baumgardner, M.D., Cleveland; Howard University College of Medicine, Washington, D.C., 1920; age 79; died January 9; member OSMA and AMA.

Ronald Christman, M.D., Woodsfield; Ohio State University College of Medicine, 1960; age 45; died January 7; member OSMA and AMA.

Charles D. Houck, M.D., Canton; Medical College of Virginia, 1944; age 55; died December 15; member OSMA and AMA.

Robert H. Kelly, M.D., August, Kansas; Case Western Reserve Medical School, 1959; age 43; died January 15.

Herbert Knodt, M.D., Columbus; University of Berlin, Germany, 1948; age 55; died May 29; member OSMA and AMA.

Edward A. Kuck, M.D., Cincinnati; University of Cincinnati School of Medicine, 1913; age 86; died January 12; member OSMA and AMA.

Evert J. Marsh, M.D., Broadway; Ohio State University College of Medicine, 1908; age 90; died January 5; member OSMA and AMA.

Lad R. Mezera, M.D., Phoenix, Arizona; St. Louis University School of Medicine, 1935; age 65; died January 10.

Alfred D. Miessner, M.D., Port Clinton; Rush Medical College, Chicago, 1935; age 69; died December 22; member OSMA and AMA.

Harry A. Minthorne, M.D., Columbus; Ohio State University College of Medicine, 1915; age 83; died January 8; member OSMA and AMA.

George C. Mynchenberg, M.D., Elyria; University of Cincinnati College of Medicine, 1924; age 78; died January 7; member OSMA and AMA.

Hugh C. Schick, M.D., Xenia; Ohio State University College of Medicine, 1927; age 80; died December 20; member OSMA and AMA.

Cleveland Academy Speaks to Community

Is there a Huntley or Brinkley among the physician population of Ohio? Are there physicians who can communicate well with the lay audience in order to express the opinions of the medical profession? In order to further the effectiveness of modern medicine, good public relations between physicians and patients are becoming necessities of life.

The Cleveland Academy of Medicine has delved into the pool of public relations on many fronts. Currently, the academy has several distinct public relations operations in effect. Some are quite visible due to weekly exposure, while others provide behind-the-scenes preparation of the physician in order to face an audience.

One of the Cleveland Academy's longest running programs is "Health Lines," a daily radio broadcast hosted by Executive Director Robert A. Lang. This five-minute program, sponsored by Blue Cross/Blue Shield, is carried on ten stations in the Cleveland area. Mr. Lang hosts five separate programs a week, each of which focuses on one area of scientific medicine. The interview format features primarily Cleveland physicians, but dentists or other professionals may appear. Physicians are selected to represent all areas of Cuyahoga County and all medical specialties.

Due to the fact that program time is purchased rather than donated, "Health Lines" has been able to acquire prime listening time. "Drive time," the period during which Clevelanders commute to and from their jobs, has proved the most successful air time. Approximately 1,200,000 Cleveland-area residents listen to "Health Lines" regularly. This audience ranges from Mansfield to Erie.

"Health Lines" has been successful in not only disseminating medical information, but also in providing a positive view of the Cleveland physician in the eyes of the public. This occurs because the lay person hears the physician discussing some medical question in a friendly manner. The public recognizes that the physician is concerned about and involved with the general Cleveland population.

Robert Lang brings to "Health Lines" a wealth of experience. Having received a doctor of philosophy degree in speech from Northwestern University, Chicago, Mr. Lang taught speech communication at Western Reserve University before joining the Cleveland Academy staff. While at Western Reserve University, he hosted a radio program entitled "Radio Roundtable." After joining the academy, Mr. Lang did a half-hour discussion format, "The Doctor Speaks," for radio.

As far as the academy knows, "Health Lines" is the only program of its type in the United States. It has been broadcast for the past ten years.

Mr. Lang is also responsible for speakers' training courses directed at educating the physician in how to be a better communicator. Mr. Lang instituted courses at the academy because physicians were often called upon by the media to comment on various topics; but in all but a few instances, none of the physicians had any training in the art of communication. Robert Lang's first course was a ten-week, two-hour-per-session undertaking. John H. Budd, M.D., AMA Trustee and candidate for AMA President-Elect, enrolled in this course.

Mr. Lang also trained physicians in the art of speaking by forming and coaching physician-member debate teams. For years he had teams debating the pros and cons of the Medicare question. These teams would debate before audiences upon request.

From these local undertakings, Mr. Lang went on to design the AMA Speakers and Leadership Seminars. These courses make use of the videotape in order to instruct students, and they are planned to identify and enhance the public communication skills of participants. Recently, Mr. Lang has cut back his actual appearances at these programs and now attends 5 or 6 of the total 12 to 20 AMA Speakers and Leadership Seminars sponsored throughout the year.

Men who have benefited from Robert Lang's tutelage include the many presidents of the Cleveland Academy of Medicine who have served during his 18 years on the staff. Frederick T. Suppes, M.D., President of the Cleveland Academy and a solo family practitioner, is often called upon by the media to address some medical question. As president of the academy, he must act as spokesman on topics for which he has little time for preparation. He appears on scheduled programs, performs in television news slots, and often gives taped telephone releases. He endeavors to present the consensus opinion of the academy, although at times he has addressed questions with his own opinion. In such cases, he has indicated that the statements are his opinion.

Dr. Suppes found the malpractice question and the definition of death stand easy topics to handle. On the other hand, when a reporter called him in the wee hours of the morning concerning the Federal Trade Commission advertising suit, Dr. Suppes knew nothing about the



Patrick S. Metro, D.D.S., of Cleveland, (left) is interviewed by Robert A. Lang on the radio program "Health Lines."



Looking over material for a news broadcast are (left to right) Theodore J. Castele, M.D., and Alexander Lagusch.

subject. The toughest assignment was a half-hour television program, "City Camera," on malpractice. During this program, Dr. Suppes had three people questioning him.

Another beneficiary of the Lang speech courses is Theodore J. Castele, M.D. Dr. Castele, Past-President of the Cleveland Academy, is the physician medical commentator for the ABC television station serving the Cleveland area.

This television role originated with stimulus from the Cleveland Academy's Public Relations Committee which felt that the academy should have more community visibility. A search was then made for a television station that might be interested in broadcasting medical information on a regular basis with emphasis on fitting the information into the news programming.

When ABC committed itself to this type of programming, it searched for a physician with the necessary qualities to broadcast a one-minute, medical-news format approximately three times per week.

Dr. Castele now appears on the 6 and 11 PM news

shows about three times a week. His programs vary, but all employ consultants in order to present the most accurate facts about the subject. Each minute spot is shot live with "Action Cam" equipment. The station makes great use of visuals and shies away from the "talking head" concept of just showing Dr. Castele. Dr. Castele notes that it takes one to two hours to prepare a minute's worth of film. Approximately 300,000 Clevelanders watch the 6 PM news with another 500,000 tuning in to the 11 PM program. These viewers represent a 70 to 100 mile radius of Cleveland.

Again, like Dr. Suppes, Dr. Castele attempts to represent the majority opinion of the Cleveland Academy on all issues. On controversial subjects, he always gives the official position of the academy.

Once a month Dr. Castele also does a one-half hour segment of the morning talk show "Morning Exchange."

Dr. Castele recalled with a chuckle the show he liked doing best. It was a program on smoking broadcast on "Morning Exchange." A heavy cigar smoker for years, Dr. Castele gave them up shortly before this performance.

"I used to walk into an academy board meeting, lay out my cigars, and state: 'when the cigars are gone, the meeting's over.'"

Another public relations endeavor of the Cleveland Academy is the medical news slots taped by Assistant Executive Director Alexander Lagusch. Mr. Lagusch tapes medical news for a radio frequency picked up by special radios owned by physicians in 20 cities in the Cleveland area. This news is broadcast seven days per week and is strictly geared to the physician audience.

The Cleveland Academy of Medicine is a leader in the concept of good physician-patient public relations. They recognize the necessity to place medical news in front of the lay population in a manner that indicates the interest of the physician in the patient. All of those involved in media programs at the Cleveland Academy and at the OSMA have indicated their willingness and desire to assist other Ohio academies in developing public relations programs. Possibly if each physician worked just a bit at better communication with the patient, the entire profession might find a greater understanding of its concerns developing in the American public.



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PHYSICIAN AND HOSPITAL EQUIPMENT

Medicare Carrier Performance

Hugh F. Hughes, Manager, Medicare Field Operations, Nationwide Insurance Company

For the fiscal year ending June 30, 1975, Nationwide Insurance, the Medicare Part B carrier for Ohio and West Virginia, achieved the number 1 rating in productivity of the 47 Medicare carriers in the United States. Productivity is based on the number of claims processed per full-time employee in a 12-month period. Nationwide's claim productivity was 9,191 claims processed per employee compared to the national average of 5,139 claims. In fiscal year 1972, Nationwide had a staff of 640 to process 2,336,300 claims. In fiscal year 1975, 355 employees processed 3,262,799 claims.

As in any business operation, productivity impacts administrative cost, an area in which Nationwide Insurance also excelled. During fiscal year 1975, Nationwide's administrative cost per claim processed was \$2.60, compared to the national average of \$3.21. Viewed from another perspective, Nationwide's administrative cost was 6.7 percent of the amount of benefits paid, compared to the national average of 8.4 percent. Nationwide's administrative cost per claim was the lowest of all carriers in their peer group, ie, carriers processing a comparable volume of claims, and fifth best among all carriers. Only four carriers, those with small claim volume and service areas, had a better cost record.

During fiscal year 1975, Nationwide received 3,293,897 claims, an increase of 22.6 percent over the prior fiscal year, and processed 3,262,779 claims. Timeliness of claim processing was among the best in the country. More than 73 percent of all claims received were processed within 15 days after they were received at Nationwide's Medicare processing center in Columbus, Ohio. Nationwide also excelled in the number of claims pending to be processed (Weeks Work on Hand) and the percent of claims pending over 30 days.

All Medicare carriers are required to meet quality standards built into the program. Nationwide utilizes processing quality control programs including sophisticated electronic data edit checks to maintain quality processing standards. This, together with field evaluation of provider/beneficiary satisfaction with claim processing timeliness and effectiveness, assures continued high quality performance.

Benefit Cost Containment is an area where it is an-

ticipated that carrier performance will be measured and compared in the future. This measurement relates to the carrier's ability to control program abuse including overutilization and potential fraud. Much of the federal government's concern in this area has been generated by the increasing cost of health care and by media reports of alleged program abuse and fraud that have been published during the past year. Nationwide Insurance expects to meet this challenge in a responsible manner. Existing utilization and integrity control programs will be modified as necessary to meet program requirements and will be conducted in a manner that will assure equity and due process with a recognition of accepted medical practice and the essential components of quality health care.

Improvement in internal claim processing procedures remains a continuing challenge, and Nationwide is dedicated to achieving top performance ratings in all measurement categories. Externally, carrier performance is impacted by the quality of claim submissions, which is directly reflected in the carrier's claim development rate (development rate is the ratio of claims requiring additional information—such as name, address, health insurance number, date of service, treatment, diagnosis—to total claims received).

Nationwide's development rate for the first six months of fiscal year 1976 was 14.4 percent, compared to 12.6 percent for the first six months of fiscal year 1975. Obviously, this trend is in the wrong direction, since the average cost of developing required information to process a claim is in excess of \$0.80. This translates into an annual program cost of over \$400,000. And this does not take into consideration the cost to the provider in responding to written communications or the interruptions of busy office schedules by patient inquiries and telephone calls from the carrier.

A carrier is not permitted* to pay a claim until all required information is obtained. Developing a claim is costly and adversely affects timeliness and productivity. A major portion of the missing information on a claim relates to items normally accessible to the provider, ie, date and place of service, description of medical treatment, services or supplies furnished, and the diagnosis or nature of the illness or injury requiring services or supplies.

When the provider completes the 1490 claim form, the need for additional claim development is far less than when the beneficiary completes and submits the claim for payment. Studies made by Nationwide Insurance reveal that the development rate on nonassigned claims is more than five times greater than the rate on assigned claims.

The following data show a comparison of trends in claim development rate and assigned claims ratio.

ASSIGNMENT RATIO

	7/1/1974	12/13/1975
Ohio	32.4%	31.8%
West Virginia	60.9%	52.7%
Combined	37.2%	35.7%

CLAIM DEVELOPMENT RATE

	7/1/1974	12/31/1975
Ohio	12.4%	15.0%
West Virginia	8.1%	11.1%
Combined	11.6%	14.4%

While these figures show that the development rate increases as the assignment ratio decreases, the critical factor is not acceptance of assignment but who completes the claim. The Medicare Law gives the provider of Part B services the option of accepting or not accepting assignment of benefits. Most physicians do not accept assignment, except for welfare recipients, due to the economic impact of program specifications for determining the allowable charge upon which benefit payments are based and philosophical objections to government involvement in the delivery of health care. Yet, many practitioners who do not accept assignment of benefits have found it economically advisable to prepare and submit their patients' Medicare claims to the carrier, thus enhancing patient relations, improving cash flow, and eliminating or substantially reducing office interruptions and expense related to claim development.

To assist physicians and other practitioners of health care whose services are covered under Medicare, Nationwide Insurance has developed programs and procedures for the mechanical or electronic data completion of claims. These programs are generally compatible with the numerous office accounting and billing systems available in today's market. Nationwide's field staff is available to explain these programs and assist in coordinating Medicare billing concepts that are of mutual benefit to the physician and the carrier.

Nationwide Insurance is dedicated to performance excellence. This means being responsive to the beneficiary, the provider of service, and program requirements. It also means responsible stewardship of public funds: paying only those benefits provided by law and keeping administrative costs as low as possible consistent with effective program administration. And most importantly, it means demonstrating the present and future ability of the private sector to perform—independently—in an efficient and effective manner.

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Summit County Medical Society Dedicates Memorial Hall

January marked the official opening of the Memorial Meeting Hall of the Summit County Medical Society. William Dorner, Jr., M.D., President of the Summit County Medical Society, accepted the hall from the Summit County Medical Service Bureau on behalf of the academy.

Of special interest were the memorial meeting chairs which were purchased by area physicians and dedicated in either the purchaser's name or in the name of another physician. Each chair is adorned with a plaque indicating to whom it is dedicated. Honorary chairs were dedicated to James L. Henry, M.D., Thomas J. O'Grady, M.D., and P. John Robechek, M.D., to show the appreciation of the Summit County Medical Society for their assistance in the formation of the OSMA 12th Councilor District.

Other highlights of the evening included the presentation of 50-year awards by Maurice L. Lieber, M.D., OSMA President. Featured speaker of the program was John H. Budd, M.D., Secretary-Treasurer of the AMA and candidate for AMA President-Elect.

The meeting was concluded by the passing of the gavel from outgoing president Dr. Dorner to President-Elect Rocco Antenucci, M.D.

74th Annual Meeting for Toledo

The Academy of Medicine of Toledo and Lucas County held its 74th Annual Meeting during January. Among the many invited guests were OSMA Executive Director Hart Page and OSMA Director of Field Services Robert Holcomb. A main feature of the evening was the passing of the gavel from John A. Devany, M.D., to Incoming President Thomas J. O'Grady, M.D.

John A. Sheridan, President of John Sheridan Associates, Inc., was the guest speaker. In his address entitled "Physicians and Their Labor Pains," Mr. Sheridan indicated that the medical society was constructed for scientific endeavor but this single purpose is passé today. The profession must also cope with bipartisan politics by electing friends and defeating enemies. With identified and educated key people to serve as resource people, the society at all levels can achieve these ends.

After leaving college, this labor relations specialist served as an organizer for a large local of a major, international union. Currently he is President of John

Sheridan Associates, Inc., which has consulted with the State Medical Society of Wisconsin during its formation of the Wisconsin Physicians' Alliance. This program, Mr. Sheridan said, contains the prerequisites of involvement, commitment, and participation by physicians.

Mr. Sheridan was recently retained by the AMA to conduct a series of regional seminars and institutes commencing in February around the country on the subject of negotiation.

Columbus Academy Outlines Plans For Implementation of Ohio Medical Malpractice Act

During January, the Academy of Medicine of Columbus and Franklin County, in conjunction with the Columbus Bar Association, outlined plans for a cooperative effort designed to implement the Ohio Medical Malpractice Act. The two organizations are concerned that the act work fairly and justly for physicians, attorneys, and the citizens of the Franklin County area.

According to Judge John McCormac, President of the Columbus Bar Association, "Our goal, insofar as professional practice liability is concerned, is quite simple. We believe that if a valid claim is filed, it should be recognized and disposed of as expeditiously as possible by a fair and just award. If an invalid claim is filed, it should be rejected as quickly as possible.

The bar association and the academy believes that the key to the mandatory, non-binding arbitration process provided for by the malpractice bill is the availability to the court of a panel of prospective chairmen deemed by all parties to be fair and impartial. To achieve this goal, the two organizations, along with the Franklin County Trial Lawyers Association, the Columbus Association of Defense Counsel, the Franklin County Hospital Administrators' Council, and District VI of the Academy of Osteopathic Medicine, mutually are considering the names of persons qualified to serve as chairmen of arbitration panels.

The basic qualifications for persons on this list is that he or she be reasonably knowledgeable, fair, and impartial. The Common Pleas Court has been very cooperative and receptive to adopting a rule requiring chairmen to be appointed from this list.

This system will assure the impartiality of the panel's decision. This is important: first, because if the parties believe the panel has acted fairly, they are more likely to accept the decision, thus closing the case; and second, should the parties not accept the panel's decision, it is admissible as evidence once the claim goes to trial and will frequently be the determinative evidence to the jury as it represents a non-party's point of view.

These plans of the academy of medicine and the bar association were presented at a press conference attended by Judge McCormac and Jack Tetrick, M.D., President of the Academy of Medicine of Columbus and Franklin County.



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Found useful in the management of vertigo* associated with diseases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo*.

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Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Serum K⁺ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

*

Warning

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has

been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and

BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Colleagues in the News *(continued)*

Late in 1975, **TRENT W. SMITH, M.D.**, served as guest professor and conducted a two-day course in rhinoplasty at the Department of Otolaryngology of the All India Institute of Medical Sciences, New Delhi, India. Dr. Smith practices nasal and facial plastic surgery in Columbus.

JOSEPH SUDIMACK, JR., M.D., was elected president of the Trumbull Memorial Hospital medical staff. Dr. Sudimack is Republic Steel Corporation's Warren District physician and Trumbull County Coroner. He is a member of the American Occupational Medical Association, the Ohio State Coroners' Association, and the Trumbull County Academy of General Practice.

Also elected were **HAROLD BRODELL, M.D.**, vice-president; **ROBERT PAUL, M.D.**, secretary-treasurer; **ENGLEBERT HECKER, M.D.**, representative to the council of medical staffs; and **WILLIAM BARBA, M.D.**, alternate representative.

DONALD MILLER, M.D., former chief of surgery and past-president of the medical staff, was honored by the hospital for 20 years of service.

WALTER J. TELESZ, M.D., has assumed duties as president of the medical staff of Massillon City Hospital. **HUBERT HENSEL, M.D.**, and **HANS LINDT, M.D.**, were chosen president-elect and secretary-treasurer, re-

spectively. The staff board will include the immediate past-president **G. NEVIN SHUEY, M.D.**, and member-at-large **ROBERT ANGERMAN, M.D.**

Serving as department chiefs for 1976 at Massillon City Hospital are **NESTOR BANEZ, M.D.**, medicine; **ERNEST BREYFOGLE, M.D.**, radiology; **BRUCE D. HARROLD, M.D.**, pathology; **T. R. SOEHNLEN, M.D.**, anesthesiology; and **DONALD POCOCK, M.D.**, intensive care.

JAMES I. TENNENBAUM, M.D., Clinical Professor of Medicine and Director of the Division of Allergy at the Ohio State University Hospitals, just returned from Israel where he presented a paper at the fourth International Pediatric Allergy Symposium. Dr. Tennenbaum was recently appointed Editor of the Section of Allergy of a new continuing medical education journal, *Journal of Comprehensive Therapy*.

ALLEN E. WALKER, M.D., was elected President of the Lakewood Hospital Medical Staff, Cleveland. Dr. Walker, a dermatologist, was vice-president of the staff in 1974-1975.

The staff's new vice-president is **WILLIAM HEGARTY, M.D.**, Chief of the hospital's Section of Neurosurgery. **JAMES WOOD, M.D.**, an otorhinolaryngologist was elected to a second term as secretary-treasurer of the staff.

Ohio Health News

John H. Ackerman, M.D., M.P.H.

Director of Health

Emergency Medical Services

A statewide system of emergency medical services is being developed to insure that no Ohio citizen is more than 20 minutes from emergency medical care. A program to upgrade emergency ambulance services has been implemented. Standards have been established and certification of emergency technicians is being done.

In Ohio, more than 300,000 ambulance calls and more than 3,000,000 emergency room visits are made annually. This great demand for services makes the development of a statewide emergency medical services system mandatory. Currently, there are 22 county-wide systems in operation.

During Fiscal Year 1975, a total of 13 political subdivisions were awarded \$592,700 to purchase emergency medical equipment. These funds provided 40 new ambulances complete with communications and medical equipment. In the first five years of the program, the Department directed nearly \$3 million to local communities for the purchase of 204 ambulances and other emergency equipment.

In the near future, the Department will begin a program of upgrading or replacing emergency medical vehicles. Ideally, 800 ambulances are needed throughout

the state. The establishment of a communications network throughout the state is of primary importance to allow for an efficient, centralized communications system.

Migrant Health Services Project

The Migrant Health Services Project provides 12 health care sites throughout Ohio and a Migrant Rest Center in Liberty Center. In cooperation with the Ohio Department of Agriculture and the Ohio Bureau of Employment Services, the Department provides migrant farm workers with overnight housing, medical care, and opportunities to find farm jobs.

The Migrant Rest Center offers comprehensive health services to migrants. With the increase in the numbers of migrant farm workers seen this summer at the Center, the clinic hours were extended from two to four nights a week. Services available include medical examination, laboratory tests, x-rays, pharmaceuticals, emergency medical and dental care, dietary and general health counseling, family planning, hospitalization, outreach and transportation for health care to hospitals and other medical centers. More than 2,000 migrants received care last year.

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The Role of Estrogen Receptors in Predicting Subsequent Therapy for Recurrent Breast Cancer

Osamu Takeuchi, M.D.
Loretta Di Vecchia, M.S.
Donald G. Bronn, B.A.
William G. Pace, M.D.
John P. Minton, M.D., Ph.D.

Dr. Minton's scientific exhibit, "Breast Cancer Management 1975," was given the Cancer Award at the 1975 Annual Meeting of the Ohio State Medical Association in Columbus in May. From the interest of those viewing the exhibit, it was apparent that only a limited number of physicians understand the practical application of the determination of estrogen levels in the therapy of patients with breast or mammary gland pathology. This article by Dr. Minton and his coauthors conveys to physicians the value of this procedure in predicting response to endocrine therapy.

SINCE 1896, WHEN BEATSON¹ observed the regression of metastatic breast cancer lesions following oophorectomy, ablation of the endocrine glands has been accepted as an effective surgical treatment for patients with recurrent or advanced breast cancer. Unfortunately, clinical remission has been obtained by means of endocrine ablation in only one-third of the patients so treated.^{2,3} Jensen, et al⁴ demonstrated that the clinical response to hormone therapy could be correlated with the presence or absence of an estrogen-specific binding protein (estrogen receptor) in the cytoplasm of cancer cells. Subsequently, many investigators have attempted to detect the presence of estrogen receptors in human breast tumor specimens.⁵⁻¹² Because there are very few investigations concerning estrogen receptors in tissues of recurrent breast cancer, we undertook specific quantitative estrogen receptor assays using the dextran-charcoal

method originally described by Korenman.¹³ Values obtained in recurrent breast cancer were compared with those obtained in primary breast cancer and in benign breast tumors.

Materials and Methods

Samples were obtained from 58 patients admitted to The Ohio State University Hospitals from August 1974 through June 1975. Biopsies were taken at the beginning of the breast operation in all cases. One half of the specimen was sent for microscopic frozen-section examination and the remainder was used for estrogen receptor assay. After surrounding tissues were removed, samples were immersed directly in liquid nitrogen within 30 seconds and kept in a liquid nitrogen tank at -196C until analyses were performed.

Results

Specific estrogen-binding capacity was found in 75 percent of the patients with recurrent breast cancer and

From the Department of Surgery, The Ohio State University College of Medicine, Columbus, Ohio.

This investigation was supported in part by Public Health Service international research fellowship F-05-TW-2075-01, Public Health Service research grant CA-12287-04; The Grand Chapter of Ohio Order of the Eastern Star and Phi Beta Psi Sorority contributions; and The Ohio State University Development Fund 522809.

Reprint requests to Clinical Department of Surgery, The Ohio State University Hospitals, 410 W. Tenth Ave. (N-735), Columbus, Ohio 43210 (Dr. Minton).

Submitted August 15, 1975.

in 60 percent of those with primary breast cancer (Table 1). In contrast, among 23 benign breast tumors, including 13 fibrocystic disease, four fibrosis, three fibroadenoma, and three lipoma, estrogen receptors were found in only three cases (13 percent). Estrogen receptors in these benign tumors were less than 10 femtomoles/mg cytosol protein (Table 2). Interestingly, typical changes in pathologic findings, such as intraductal papillomatosis, florid adenosis, or fibroadenoma, were demonstrated.

Results of assays in 20 cases of recurrent breast cancer are shown in Table 3. The concentration of estrogen receptors varied over a wide range from 2 femtomoles/mg to more than 100 femtomoles/mg cytosol protein. Dissociation constants fell in a narrow range from $6.8 \times 10^{-11}\text{M}$ to $5.6 \times 10^{-10}\text{M}$. In three cases in which biopsies were taken from regional lymph nodes, all

TABLE 1. Estrogen Receptors in Recurrent and Primary Breast Cancers and Benign Breast Tumors.

Diagnosis	Negative	Positive (Fmoles/Mg Cytosol Protein)		
		<10	10 to 100	>100
Recurrent breast cancer	5	5	8	2
Primary breast cancer	5	2	7	1
Benign breast tumors	20	3	0	0

TABLE 2. Positive Estrogen Receptors in Benign Breast Tumors

Patient	Age	Pathology	Kd*	Fmoles/Mg Cystol Protein
1	54	Intraductal papillomatosis	$4.0 \times 10^{-10}\text{M}$	7.7
2	49	Fibrocystic disease		
		florid adenosis	$5.0 \times 10^{-10}\text{M}$	4.2
3	38	Fibroadenoma	$1.4 \times 10^{-10}\text{M}$	2.8

*Dissociation constant

TABLE 3. Estrogen Receptors in Recurrent Breast Cancer.

Patient	Age	Site of Biopsy	Kd*	Fmoles/Mg Cytosol Protein
1	70	Rt chest wall	$3.0 \times 10^{-10}\text{M}$	143.5
2	71	Lf chest wall	$6.6 \times 10^{-10}\text{M}$	117.5
3	45	Supraclavicular lymph node		
			$3.6 \times 10^{-10}\text{M}$	79.2
4	57	Lf chest wall	$2.0 \times 10^{-10}\text{M}$	36.3
5	33	Supraclavicular lymph node		
			$4.8 \times 10^{-10}\text{M}$	34.4
6	61	Rt chest wall	$7.7 \times 10^{-11}\text{M}$	31.6
7	47	Lf chest wall	$1.5 \times 10^{-10}\text{M}$	28.3
8	51	Lf chest wall	$4.8 \times 10^{-10}\text{M}$	19.3
9	49	Rt chest wall	$3.6 \times 10^{-10}\text{M}$	19.1
10	35	Rt chest wall	$1.8 \times 10^{-10}\text{M}$	14.0
11	74	Rt chest wall	$5.6 \times 10^{-10}\text{M}$	7.8
12	63	Rt chest wall	$2.5 \times 10^{-10}\text{M}$	3.1
13	53	Lf chest wall	$2.6 \times 10^{-10}\text{M}$	2.6
14	60	Axillary lymph node		
			$6.8 \times 10^{-11}\text{M}$	2.0
15	68	Lf chest wall	$1.8 \times 10^{-10}\text{M}$	2.0
16	52	Lf chest wall		Negative
17	67	Rt chest wall		Negative
18	46	Rt chest wall		Negative
19	53	Lf chest wall		Negative
20	57	Rt chest wall		Negative

*Dissociation constant

TABLE 4. Estrogen Receptors in Primary Breast Cancer.

Patient	Age	Pathology	Positive Node	Kd*	Fmoles/Mg Cytosol Protein
1	58	Ductal carcinoma	2/21	$2.5 \times 10^{-10}\text{M}$	104.2
2	34	Ductal carcinoma	3/14	$6.1 \times 10^{-11}\text{M}$	45.6
3	87	Adenocarcinoma	Negative	$1.9 \times 10^{-10}\text{M}$	40.4
4	80	Adenocarcinoma	Negative	$2.8 \times 10^{-10}\text{M}$	40.3
5	68	Ductal carcinoma	6/9	$1.2 \times 10^{-10}\text{M}$	30.0
6	71	Ductal carcinoma	Negative	$1.5 \times 10^{-10}\text{M}$	22.6
7	65	Ductal carcinoma	5/18	$3.6 \times 10^{-10}\text{M}$	20.7
8	52	Ductal carcinoma	4/14	$2.6 \times 10^{-10}\text{M}$	10.0
9	51	Lobular carcinoma	Almost positive	$3.8 \times 10^{-10}\text{M}$	9.4
10	44	Ductal carcinoma	Negative	$2.0 \times 10^{-10}\text{M}$	3.9
11	38	Ductal carcinoma	1/14		Negative
12	42	Adenocarcinoma	19/28		Negative
13	61	Adenocarcinoma	Negative		Negative
14	49	Adenocarcinoma	Negative		Negative
15	30	Ductal carcinoma	Negative		Negative

*Dissociation constant

showed positive estrogen receptor assays with a span of 2.0 to 79.2 femtomoles/mg cytosol protein. Chest wall biopsies were obtained in 17 cases. These also showed a wide range including five cases that were entirely negative. Of the remaining 12 positive cases, four were less than 10 femtomoles and 8 ranged from 14.0 to 143.5 femtomoles/mg cytosol protein.

Results in 15 cases of primary breast cancer are shown in Table 4. Concentrations of estrogen receptor varied over the same wide range as those in recurrent breast cancer. Negative results were obtained in five cases, and estrogen receptors in eight cases ranged from 10.0 to 104.2 femtomoles/mg cytosol protein. Only one case showed less than 10 femtomoles/mg cytosol protein. There were no significant correlations between estrogen-binding capacity and other factors, such as the patient's age or the pathologic findings. In neither recurrent nor primary breast cancer was there any correlation between estrogen receptors and menopausal age.

Discussion

Korenman's¹³ dextran-charcoal method* used in this study permitted the accumulation of accurate quantitative data. It is relatively easy and satisfactory for use as a routine assay. Furthermore, compared to the in vitro tissue-slice uptake method,^{5,7,8} which is not quantitative and requires additional controls to insure specificity, the dextran-charcoal method provides useful quantitative data which aids in judging indications for ablation surgery and determining responses to operations.

Slight elevation of estrogen receptors found in several benign tumors has been also demonstrated by other authors.^{6,9,14} In studies by Terenius, et al,¹⁴ benign tumors with atypical histologic features are assumed to have estrogen receptors.

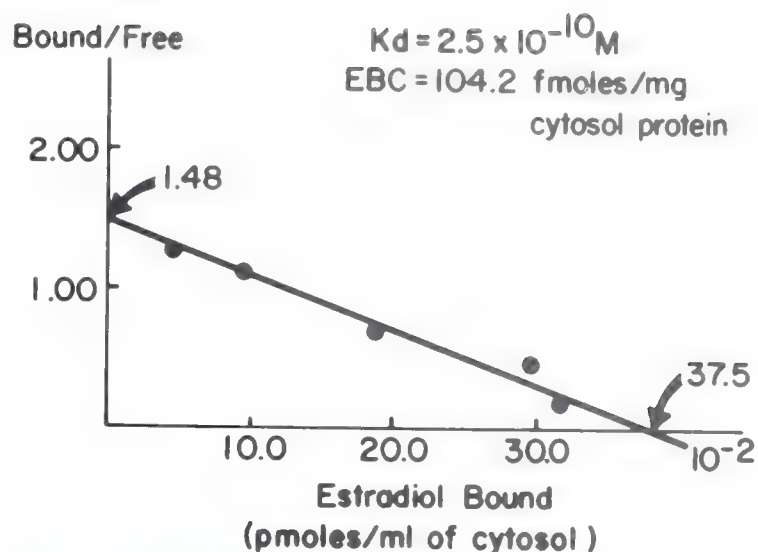
In either recurrent or primary breast cancer, the concentrations of estrogen receptor levels varied over a

*Details available from the authors upon request.

wide range, while the dissociation constant fell in a narrow range. As other investigators showed,^{8,12} this indicates that there are no differences in estrogen receptors between recurrent and primary breast cancer. But, in recurrent breast cancer, especially when skin biopsies were taken from the chest wall, we obtained five negative results and four low estrogen-receptor values (less than 10 femtomoles/mg cytosol protein). Since skin biopsies of recurrent breast cancer may contain fewer cancer cells than those of the primary tumor, the results obtained from these biopsies should be considered with the histologic findings. Repeat assays would be necessary in some cases. Therefore, even in patients with stage I tumor, an estrogen receptor assay should be done at the time of the first operation. An estrogen receptor assay of the axillary lymph nodes also would be helpful, should the tumor recur. Other lymph nodes, such as supra- or infraclavicular nodes, also should be chosen for assay, if possible. Whenever a skin biopsy is taken, care should be exercised in choosing a site which is sufficient in cancer cells for the assay.

The consistency in our experiences with the estrogen receptor assay has afforded us greater confidence in our ability to recommend endocrine ablation to the patient who has been profiled for estrogen receptors. McGuire, et al¹⁵ have indicated that in a study of 20 patients with positive tumor estrogen-receptor (ER) values, 12 responded to surgical endocrine ablative therapy, and in 15 patients with negative tumor ER values, there was no response. Furthermore, tumor ER levels were used as an index for predicting responsiveness to endocrine therapy. A 50 percent response rate was obtained at ER values between 3 and 10, and a 66 percent response rate for ER values between 11 and 100, with a 100 percent response rate for two cases with very high values (over 100 femtomoles/mg cytosol protein).

Our observations also were consistent with those of McGuire, however, we usually performed bilateral adrenalectomy and bilateral oophorectomy when the estrogen receptor value was greater than 20 femtomoles/mg cytosol protein. A case in point would be a 33-year-old white woman who underwent a right, simple mastectomy in 1971 for cancer. In 1973, the patient underwent an axillary-node dissection at which time three positive nodes were found. In February 1974, the patient had a suture-line recurrence of the carcinoma removed. She was referred for the first time to The Ohio State University Hospitals for bacille Calmette Guerin (BCG) immunotherapy. In October 1974, right supraclavicular-node



Typical Scatchard's plot of estrogen-binding capacity (EBC) in human breast cancer. Data are plotted in this form to yield maximum number of estradiol binding sites at infinite estradiol concentration/mg protein concentration. Dissociation constant (Kd) is approximated by dividing abscissa intercept by ordinate intercept.

biopsy confirmed metastatic breast carcinoma, and a specimen for estrogen receptor assay was taken at that time. The patient was placed on Cytosan®, vincristine, 5-fluorouracil, and Methotrexate® therapy. While on the four-drug therapy, the tumor's relentless proliferation showed no manifestation of abating. Therefore, in view of the fact that the patient's estrogen receptor level was 34.4 femtomoles/mg cytosol protein, she was reevaluated for bilateral adrenalectomy and bilateral oophorectomy. The surgery was performed in December of 1974 without complication. Consequently, 11 months after endocrine ablation, no evidence of tumor can be detected in this patient, and it would appear that complete remission has been achieved.

This case vividly illustrates the predictability available with estrogen receptor assay. It also points out that immuno- and chemotherapy failure cannot be used as criteria for judging the effectiveness of endocrine ablation, especially when indicated by estrogen receptor assay.

Summary

Endocrine ablation, such as adrenalectomy or oophorectomy, is the therapy of choice in recurrent breast cancer. It has been demonstrated recently that clinical response to hormone therapy is correlated with the presence of estrogen receptors (ER) in tumor tissue. Therefore, measurement of ER in patients with recurrent breast cancer is a very valuable factor in weighing indications for endocrine ablation. Because there are few reports concerning ER in recurrent breast cancer, we measured ER in 20 recurrent breast cancer patients and compared results with values found in 23 benign breast tumors and in 15 primary breast cancers. Scatchard's plot was used to obtain values of ER. (See Figure.)

In 3 of 23 benign breast tumors and 10 of 15 primary breast cancers, ER assay was positive. A wide range of

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estrogen-binding values was seen in both primary and recurrent breast cancer.

It is suggested that an ER assay of metastatic breast cancer be performed routinely on any readily accessible site before considering endocrine ablation. Since such an assay has a demonstrated value in predicting response to endocrine therapy, its routine use would thereby eliminate much ineffective and unnecessary surgery.

Acknowledgment: Richard H. Matthews, Ph.D., Associate Professor of Physiological Chemistry, The Ohio State University, assisted in this study.

References

1. Beatson GT: On the treatment of inoperable cases of carcinoma of the mamma: suggestions for a new method of treatment with illustrative cases. *Lancet* 2:104-107, 162-165, 1896.
2. Taylor SG III: Endocrine ablation in disseminated mammary carcinoma. *Surg Gynecol Obstet* 115:443-448, 1962.
3. MacDonald I: Endocrine ablation in disseminated mammary carcinoma. *Surg Gynecol Obstet* 115:215-222, 1962.
4. Jansen EV, Block GE, Smith S, et al: Estrogen receptors and breast cancer response to adrenalectomy. *Natl Cancer Inst Monogr* 34:55-71, 1971.
5. Johansson H, Terenius L, Thoren L: The binding of estradiol-17-beta to human breast cancers and other tissues *in vitro*. *Cancer Res* 30:692-698, 1970.
6. Feherty P, Farrer-Brown G, Kellie AE: Oestradiol receptors in carcinoma and benign disease of the breast: an *in vitro* assay. *Br J Cancer* 25:697-710, 1971.
7. James F, James VH, Carter AE, et al: A comparison of *in vivo* and *in vitro* uptake of estradiol by human breast tumors and relationship to steroid excretion. *Cancer Res* 31:1268-1272, 1971.
8. Maass H, Engel B, Hohmeister H, et al: Estrogen receptors in human breast cancer tissue. *Am J Obstet Gynecol* 113:377-382, 1972.
9. Wittliff JL, Hilf R, Brooks WF Jr, et al: Specific estrogen-binding capacity of the cytoplasmic receptor in normal and neoplastic breast tissues of humans. *Cancer Res* 32:1983-1992, 1972.
10. Hähnel R, Twaddle E: Estimation of the association constant of the estrogen-receptor complex in human breast cancer. *Cancer Res* 33:559-566, 1973.
11. Engelsman E, Korsten CB, Persijn JP, et al: Human breast cancer and estrogen receptor. *Arch Chir Neerl* 25:393-397, 1973.
12. McGuire WL: Estrogen receptors in human breast cancer. *J Clin Invest* 52:73-77, 1973.
13. Korenman SG, Dukes BA: Specific estrogen binding by the cytoplasm of human breast carcinoma. *J Clin Endocrinol Metab* 30:639-645, 1970.
14. Terenius L, Johansson H, Rimsten A, et al: Malignant and benign human mammary disease, estrogen binding in relation to clinical data. *Cancer* 33:1364-1368, 1974.
15. McGuire WL, Pearson OH, Segaloff A: Predicting hormone responsiveness in human breast cancer, in McGuire WL, Carbone PP, Vollmer EP (eds): *Estrogen Receptors in Human Breast Cancer*, New York, Raven Press, 1975, pp 17-30.

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Controlling Incontinence Among Geriatric Patients

A Pilot Study Made in a State Mental Hospital

William R. Chambers, M.D.
William E. Lyon

Of all the infirmities of the elderly, incontinence is the most demeaning to them and the most repugnant to other people. However, very little is written about its control.

A pilot program conducted in a state mental hospital is presented. It was felt to be highly successful.

ONE VERY FREQUENT reason for sending old folks into institutions such as mental hospitals is that they are incorrigibly incontinent. It is seldom mentioned on the hospital admission sheet, but careful questioning of the family reveals what they were ashamed to mention—incontinence was the “last straw.”¹ Oversized diapers, either regular or disposable, can be bought at the neighborhood drugstore, however, wearing a diaper like a baby causes regression, withdrawal, and misbehavior in other aspects of life. Also, there is the ever-present odor which repels visitors and alienates friends.

This report does not pretend to rank as research, but simply to demonstrate that with the patient as his own control, a majority of elderly patients in a mental hospital can be kept dry. Our study lasted six weeks.

Subjects were chosen from the ambulatory patients on the infirmary wards. The criteria were:

1. They were the most consistently incontinent patients on the ward, having to be changed frequently, both day and night.
2. They were able to get from the bed to the bathroom.
3. They had no disease or physical condition which

would contribute to incontinence of bladder and/or urinary tract, or which would cause the incontinence.²

Method

Patients in this hospital were aroused and dressed from 5 AM to 5:30 AM, and the following program was instituted. Only three to six patients were chosen from three separate wards, two female and one male. There was a total of 16 patients ranging in age from 65 to 81 years.

- 5 AM—Taken to toilet and given 8 oz of fluid.
- 7 AM—Given 8 oz of fluid and a diuretic.
- 9 AM—Toileted and given 8 oz of fluid.
- 11 AM—Given 8 oz of fluid.
- 1 PM—Toileted and given 8 oz of fluid.
- 3 PM—Given 8 oz of fluid.
- 5 PM—(Suppertime) Toileted and given 8 oz of fluid. (No more fluids were allowed until 5 AM the next day.)
- 7 to
- 8 PM—(Last medicine call) Patient usually was given 50 mg orphenadrine (other medication in some cases).
- 2 AM—Patient was awakened, toileted, and given 50 mg orphenadrine. Since all of these patients were on a regimen of some form of phenathiazene, orphenadrine was given to control the extrapyramidal reactions. It was just fortunate that it also had the property of urinary retention.

Preparation of the Patient

Laboratory tests were made for serum potassium, sodium, and carbon dioxide values. We ordered a great many more tests at first but finally settled on these three to be made weekly. An electrocardiogram was made at fairly regular intervals to watch for signs of potassium

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Submitted August 25, 1975.

depletion. Liquids given were largely fruit juices. Results of the weekly blood tests remained completely within normal limits in all cases. None of the electrocardiograms, taken as near two-week intervals as possible, indicated hypopotassemia.

On one male ward, the patients to be tested were fully briefed before starting the program. On the other two female wards, only a short statement was made, and the patient was given a choice as to whether she would like to become dry. Original responses from the patients were affirmative. In the end, short or long briefings appeared to make no difference in the results.

On two of the wards (one male and one female), a college student on summer vacation was employed. His chief duty was to see that the program was carried out. The ward personnel on the third ward (female) was able to carry out the program without outside help, and they did a good job of it.

A pleasant discovery occurred to the investigator. A silent, but palpable reluctance to start such a program was noted originally. This reluctance was interpreted by the investigator as lack of concern for the patients and disinclination to work on the part of the ward personnel. However, as he worked daily on each of the involved wards with the personnel there, an opposite view quickly became apparent. He found the great majority of the personnel to be involved, dedicated, compassionate people with a deep personal concern for each of their patients. They had to be such people since they were dealing with perhaps the most difficult of all patients—the aged, the psychotic, and the ill. Such patients show a continuous and dull apathy, seldom uttering a word of thanks or appreciation, confused, getting into other patients' belongings, tearing up ward equipment, and even occasionally becoming unreasonably violent. Great credit that the project could succeed at all must be given to the ward personnel. The reluctance appeared to be ideologic and psychologic. A large movement of patients from the state hospital to nursing homes had been accomplished recently. An appreciable number of these patients had returned to the state hospital. They reported that the care in the nursing home was far inferior to that in the hospital and that they had actually feigned insanity in order to be sent back again. Therefore, they were suspicious of any change. Furthermore, rehabilitation of a geriatric patient who has been in a mental institution for 8, 10, or 12 years promises little social reward. The spirit is not the same as that of the Bureau of Vocational Rehabilitation, whose goal is returning the disabled person to gainful activity from which he can pay taxes and help to reimburse the body politic for its expense on his behalf. What happens if you rehabilitate a geriatric patient in a mental hospital? He is not likely to become gainfully employed, nor is he apt to function in such charitable activities for senior citizens as the retired senior volunteer program or foster grandparents. In most cases, as his brain becomes less and less sharp with advancing age, he eventually will have to return to some kind of sheltered, closely ordered life. One

must not underestimate the thinking ability of ward personnel.

After the project got under way, improvement in many patients engendered enthusiasm in the personnel, especially those on the night shift. (They didn't have to go around "stripping beds all night.")

When it became obvious that other patients were keeping dry, a few additional patients voluntarily asked to be included. Some patients became completely continent after only two weeks on the program. From then on, most of these went to the toilet voluntarily and have continued to do so.

The program was discontinued then. A few of those on the program continue to go to the toilet voluntarily, and they are no longer a problem. More of them merely need to be reminded, and then they toilet themselves. As predicted, many have regressed to their original state of being wet all of the time. None has been made worse by the program.

The chief reason for regression to incontinence is very simple. At the time of this study, there frequently were only two female attendants for approximately 50 elderly, infirm patients. Confused elderly people wander about, get into mischief, accidentally hurt themselves. Restraint requires a physician's order, but placing a patient in a tray chair does not. A patient in a tray chair cannot get to the toilet, and his cries for attention are just one of many a busy attendant must try to satisfy. It is a satisfaction to report that this condition is very much improved now.

The use of orphenadrine or thioridazine was discontinued with the discontinuance of the pilot project. It is felt that these drugs had a very beneficial effect on the patients, and without them, some of the patients could not maintain continence. For two-week periods, other drugs with a reputation for influencing incontinence, such as nortriptyline, were tried. Admittedly, the impression was that orphenadrine and thioridazine held a slight advantage. It is misleading and unfair to specify how many patients remained continent in contrast to how many did not. Obviously, those who improved in general behavior and who no longer were confined to tray chairs were the only ones who had a chance to remain continent once the pilot project was stopped. Most, but not all, of these did remain continent. It must be noted that those who reverted to incontinence had orphenadrine or thioridazine therapy discontinued by the ward physician, who had his own preferences of medication. The purpose of this study was to prove that infirm patients in the geriatric section of a state mental hospital could be kept dry.³ The odds against their continuing dry were too great to include such a comparison.

Results

This pilot study was felt to be a success, in that even using badly regressed patients, many could be rendered continent. The results seem to indicate that, with in-

creased staff, future attempts might show even more remarkable results.

We cite the noticeable results obtained with four patients in the study.

A 66-year-old white, married woman was brought to the hospital 2½ years ago by her family and was admitted on a voluntary basis. It was the patient's first admission here. She was admitted because she was confused, disoriented, and inappropriate in her affect. Diagnosis was organic brain syndrome.

General Behavior.—The patient was clean in her appearance. She was casually dressed. She was relaxed and calm during the interview and seemed to be quite cooperative. She showed no problem with her speech. Her facial appearance lacked any kind of expression. Motor activity was somewhat slow, but motor coordination seemed to be normal. Her mood was mildly depressed.

Stream of Mental Activity.—Patient's verbal productivity was diminished. She answered questions very briefly, mostly saying, "I don't know." Her response to questions was relevant. She showed no flight of ideas or circumstantiality. There was no language deviation or slurring of speech.

Content of Thought.—Patient denied having delusions or hallucinations, but she expressed some feelings about her neighbors "who were trying to scare her" but she didn't know why. There was no evidence of self-depreciation or obsessive ideas.

Sensorium.—The patient was completely disoriented. Her memory was greatly impaired. She couldn't remember her age or her birth date. She was unable to perform the auditory digit span (backwards)⁴ or the calculation test, and her general knowledge was very limited.

Judgment.—Impaired.
She became continent the day the program started and she has remained so, except for one episode.

An elderly man had been hospitalized for at least seven years. His exact age was not known, but he was close to 70 years old. He kept his pockets full of feces. He was incontinent, mumbled, and probably was hallucinating. He was sloppy and required constant nursing care. Diagnosis was hebephrenic schizophrenia.

He took to the program and is completely continent now. During the 42 days of the program, he was incontinent only once on two separate days.

An 81-year-old widow was admitted from a nursing home 13 years ago, excited, agitated, untidy, and with a delusion that she had given herself to the devil. Diagnosis was organic brain syndrome with senile brain disease.

At the time of the study, she was still disoriented and confused with inappropriate affect and was continuously incontinent. She had a mild form of diabetes. She con-

stantly made a nuisance of herself, getting into other patients' things and the nurses' belongings.

During the program, she was incontinent only once on one day. Her behavior improved substantially and, in less than a year, she was discharged to a nursing home.

This patient was 76 years old and had been in a state mental hospital for 44 years. The original diagnosis at this hospital was schizophrenia, hebephrenic type. There was little social history, except that she had been born in one of the Slavic countries, had a common school education, had worked as a domestic, had never married. There was no trace of her family.

On admission to this hospital, she was violent and attacked the examiner. Later, she was given the responsibility of pushing the floor polisher; and she would go merrily on her way, singing, laughing, and pushing anyone who got in the way of her polisher. At the time of the pilot study, she was untidy and it was hard to keep clothes on her. She never spoke a word and was incontinent almost all the time.

Once on the program, she was incontinent from one to three times a day, but only during a short, two-day bout of infectious diarrhea. Out of 42 days, she was otherwise incontinent only once on two days and these were days when a drug other than orphenadrine was used.

Summary

This pilot study was undertaken to show that, with a proper program, many elderly patients—some disoriented, some with much impaired memory, some confused, untidy, disturbed, annoying, some delusional, some hallucinating, and some demanding—can be rendered continent.

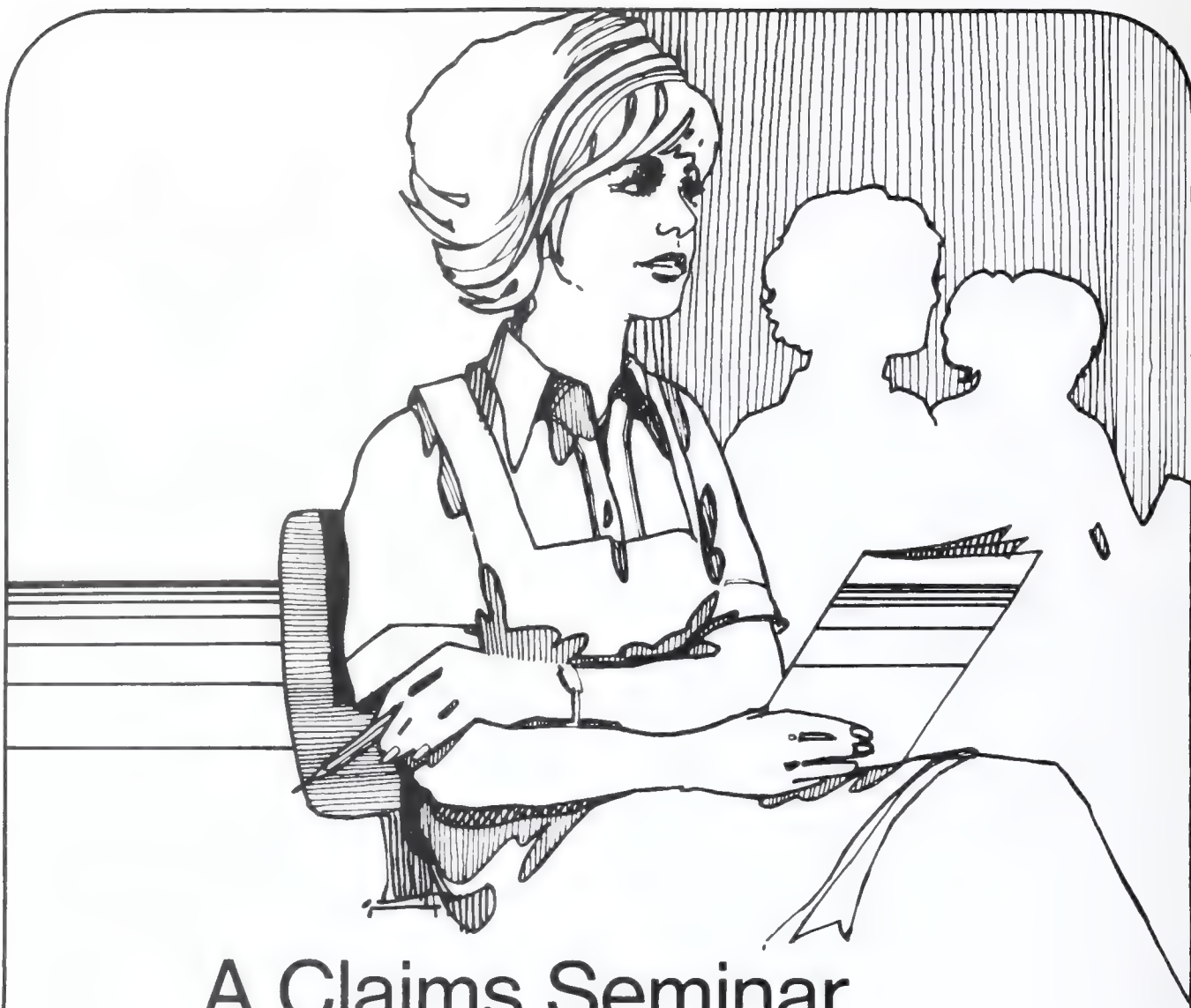
Drugs contributing to urinary retention were used. Those with a reputation for being helpful in incontinence were alternated from time to time. There seemed to be no great difference in their affect, except for a slight advantage of orphenadrine and thioridazine.

Acknowledgment: Sandoz Pharmaceuticals, East Hanover, N.J., furnished the stipend for the two student investigators who assisted in this study.

Generic and Trade Names of Drugs
Orphenadrine hydrochloride—Disipal (Riker Laboratories)
Thioridazine hydrochloride—Mellaril (Sandoz Pharmaceuticals)
Nortriptyline hydrochloride—Aventyl (Eli Lilly and Co.)

References

1. Rossman I: *Clinical Geriatrics*. Philadelphia, J B Lippincott Co, 1971, p 467.
2. Howells JG: *Modern Perspectives in the Psychiatry of Old Age*. New York, Brunner/Mazel, 1975, p 464.
3. Cowdry EV, Steinberg FU (eds): *The Care of the Geriatric Patient*, ed 4, St Louis, C V Mosby Co., 1971, p 373.
4. Wells FL, Ruesch J: *Mental Examiners Handbook* (revised), New York, Psychological Corp, 1945, p 66.



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Committee on Maternal and Neonatal Health

Abortion Today

Anthony Ruppertsberg, Jr., M.D.

IN THE PAST FIVE OR TEN YEARS, innumerable changes have occurred in our social and medical practices. The pattern of our basic culture has been remolded as a somewhat frustrated society presses toward a goal of "modernism."

The primary purpose of this article is to evaluate past and present concepts of an ancient operation originally assigned (legally) to the physician but practiced (illegally) by many others—abortion. Second, omitting any emotional or social concepts, the author presents a brief medical guideline which may be used to teach the medical student and to clarify impending administrative and professional duties affecting maternal health in Ohio.

History

Various portions of medical history gently present changes in public, political, and professional attitudes toward abortion. As early as 600 BC, "criminal abortion" operators were severely punished in the Persian Empire (Iran), whereas in the Greek and Roman eras, there was little protection for the fetus; abortion was performed without scruple. Infanticide was popular. However, Soranus (Ephesian gynecologist, 2nd century BC) was opposed to *free* abortion practices in Rome; his first thought was for the life of the mother.

Approximately 460 BC, Hippocrates swore not to produce abortion (Hippocratic oath). He advocated strict ethical concepts in medical practice. As the "Father of Medicine" and "wisest and greatest practitioner of his art," he really represented only a small segment of Greek opinion. Suicide was acceptable; but with the end of

antiquity and the emergency of the teachings of Christianity, a great change took place. The Hippocratic oath became popular, and there was marked resistance to both suicide and abortion.

Later, English statutory law provided the first criminal abortion law in 1803. Removal of the "quick fetus" was a capital crime, but a lesser crime (felony) was assigned to abortion before "quickening." This law prevailed until liberalization reforms appeared in 1967. These reforms provided legality to abortion where continuance of the pregnancy involved risk to the life of the mother, two physicians agreeing.

In Ohio, the old law regulating abortion was quite similar: "OHIO CODE: Sec. 2901.16 Attempt to Procure Abortion (GC Sec. 12412) 'No person shall prescribe or use an instrument or other means with intent to procure the miscarriage of a woman, unless such miscarriage is necessary to preserve her life or is advised by two physicians, to be necessary for that purpose. . . .'"

Definition

For simplicity, accuracy, and uniformity, we suggest the following definition: "Abortion is the interruption of a non-viable human pregnancy."¹ This usually applies before the 20th week of gestation; all of the products of conception may or may not be completely expelled. For many years, this definition has proved simple and satisfactory as a teaching concept, as well as a practical, clinical measure.

Further classification and terminology related to types has proved quite satisfactory in the past (Fig. 1).

Legal Changes

On January 22, 1973, the U.S. Supreme Court ruled that abortion laws in Texas and Georgia were unconstitutional. These two decisions affected the status of abortion laws in the remaining states. New York State

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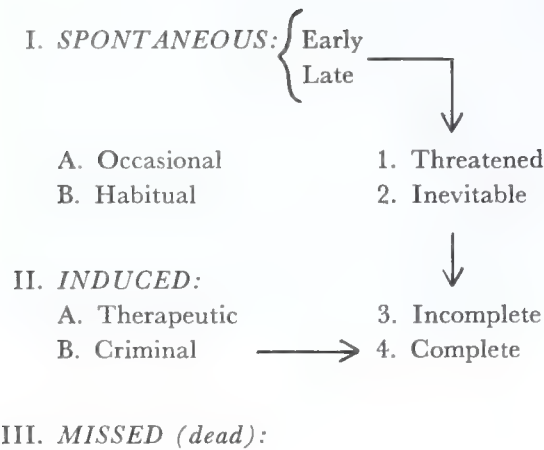


FIG. 1. Classifications of abortion types under old law, prior to 1974.

and the District of Columbia preceded this decision to liberalize abortion by two years.

All existing Ohio statutes on the subject of abortion were automatically repealed and new laws were enacted under Am. Sub. H.B. No. 989, which became effective September 16, 1974. Quoted in part, the term is defined:

"Sec. 2919.11. As used in the Revised Code, 'Abortion' means the purposeful termination of a human pregnancy by any person, including the pregnant woman herself, with an intention other than to produce a live birth or to remove a dead fetus or embryo; abortion is the practice of medicine or surgery for the purposes of Section 4731.41 of the Ohio Revised Code."

The reader will note that this definition (1) does not include spontaneous abortion, (2) nor does it specify the length of gestation of the pregnancy.

In view of these slight changes in terminology, it seems feasible that we slightly alter the original classifica-

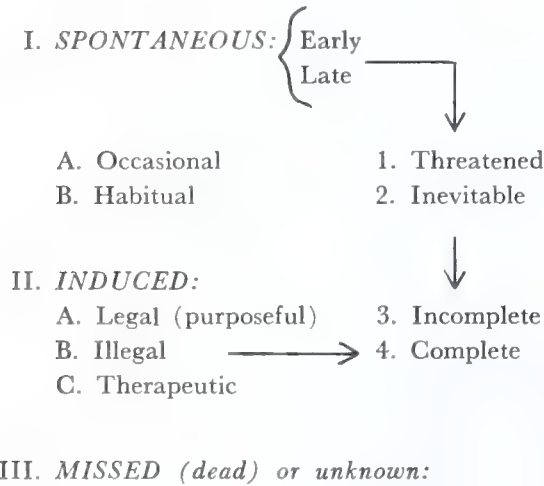


FIG. 2. Classifications of abortion types under new law, 1974.

tion used by our Committee on Maternal and Neonatal Health and use the one shown in Figure 2. Thus, in our Ohio Maternal Mortality Study,* the abortion-related deaths are listed as spontaneous, induced (legal, illegal, or therapeutic), or unknown (or missed), in accordance with terms prescribed by the Center for Disease Control (CDC), U.S. Department of Health, Education and Welfare, Atlanta, Ga.²

Statistics

One of the most compelling reasons for liberalizing abortion laws was to reduce or eliminate the disastrous effects of criminal abortions performed by unskilled persons under clandestine, unsafe circumstances. The number of illegal abortions performed in the past is not known; it can only be estimated by considering the number of abortion deaths or by hospital admissions related to sequelae following the illicit acts.

From time to time during the past 18 years, the Committee on Maternal Health of the Ohio State Medical Association focused attention on the problem of criminal abortion. The Committee published its first

TABLE 1. Ohio Maternal Deaths Involving Abortion, 1955 Through 1973 (19 Years)* from the Ohio Maternal Mortality Study

Total maternal deaths (19 years)	1194
Total abortion-related deaths	148
Spontaneous	51
Induced	97
Illegal (criminal)	95
Therapeutic	2
Missed or unknown	0

*Preliminary report only for 1972 and 1973.

article on the subject in June 1957, with four case reports.³ Subsequent articles appeared in the April 1959, September 1961, March 1964, and June 1969 issues of this *Journal*.

Data from the Maternal Mortality Study contain relative figures indicating maternal deaths associated with abortion for a period of 19 years. (See Table 1.)

The new Ohio Abortion Law, effective September 16, 1974, is well-designed to require detailed individual case reporting, pre- and post-natal counseling, patient history, physical examination, results of laboratory work, and patient follow-up. Abortion reports for each case

*A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal and Neonatal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the studies by the Committee, based on anonymous data submitted, are presented from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

must be forwarded to the Ohio Department of Health for collation. Sufficient Ohio data are not available for publication at this time, however, it is to be assumed that some excellent statistics will be forthcoming in the near future.

Overall data concerning the number of legal abortions performed in the United States, complications, and vital statistics related thereto are being collected meticulously by the CDC.² Certainly, massive statistical information will be published on the subject of abortion in another three or four years. For example, 615,831 abortions were reported to the CDC from 50 states, the District of Columbia, and New York City in 1973 (Table 2).

From a local standpoint, the number of legal abor-

TABLE 2. Selected U.S. Abortion Data for 1973, Center for Disease Control, HEW, Atlanta, Ga.

Legal abortions reported	615,831
Abortions per 1,000 live births 195*	
Reported deaths from abortion	51

*In ten states, abortions exceeded live births in patients under 20 years old.

TABLE 3. Legal Abortions Performed and Complications Recorded Over a 2½-Year Period in a Clinic Located in an Ohio City

Complications	Per 1,000 Patients
Known	4.45
Retained tissue	1.55
Perforation	1.88
Cervix laceration	1.68
Endometritis	0.45
Missed abortion	0.09
Total Patients	16,000

tions performed and the complications encountered in the clinic of one large Ohio city are presented as a small sample. (See Table 3.)

In contrast, an excellent review of maternal mortality in New York State, 1970-1972, related to legal abortions performed in the first two years of liberalization of the New York law, was published in 1974.⁴ It pointed out that 609 of the patients (for this period) were from

other states. There were 29 maternal deaths, infection being the most common cause of death. Five of eight deaths due to infection were related to "saline-induced abortion." The overall mortality rate was 6.5 per 100,000 reported legal abortions. Advanced gestation and hysterectomy appeared to be the major avoidable factors.

It may be assumed that future articles will present reports of past tragic problems, as well as the complications and successful results connected with the "old operation" (abortion) performed under "new laws." We shall continue to monitor this facet of our social and professional environment, in collaboration with state and national health offices.

Summary

Past and present concepts of an old operation (abortion) have been presented from a purely professional standpoint. A simple, practical definition classifying clinical types of abortion is offered. This meets with the categories promoted by the CDC for collection of statistics and data on a national level.

Acknowledgements: For 20 years, the dedicated efforts of members of the OSMA Committee on Maternal Health have successfully produced statistics and an educational program to reduce maternal deaths in Ohio. With a sense of pride, we focus due attention upon their accomplishments. We also acknowledge the assistance of numerous other physicians, including Willard Gates, M.D., M.P.H., and Carl W. Tyler, Jr., M.D., both of the Center for Disease Control, Atlanta, Ga.

References

1. Danford, DN: *Textbook of Obstetrics & Gynecology*, ed 2, New York, Harper & Row, 1971.
2. *Abortion Surveillance, Annual Summary, May 1965*. Department of Health, Education and Welfare, Family Planning Evaluation Division, Center for Disease Control, Atlanta, Ga.
3. OSMA Committee on Maternal Health: Maternal Health in Ohio. *Ohio State Med J* 53:671-672, 1957.
4. Berger GS, Tietze C, Pakter J, et al: Maternal mortality associated with legal abortions in New York State: July 1, 1970 — June 30, 1972. *Obstet Gynecol* 43:315-326, 1974.



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OSMA Physician Effectiveness Program Aids the Disabled MD

Physicians beset with problems of alcoholism, drug dependence, senility, or mental illness are unable to give optimal medical care to their patients.

The effects of these problems upon professional performance are often gradual and insidious, undetected by the person who is affected or by others, points out the AMA in its publication *The Impaired Physician*.

The publication emphasizes that when symptoms become evident, the disorder may well go unacknowledged by both the disabled physician and his colleagues alike. The disabled physician may feel he has no confidential source from which to seek assistance even if he realizes the extent of his problem.

Since July 1, 1975, OSMA has sponsored a Physician Effectiveness Program which endeavors—within the physician peer group—to help the physician with problems seek counseling or treatment. The program is conducted by the OSMA Committee on Mental Health.

“We hope to reach the physician before his problem affects his ability to practice,” said Milton M. Parker, M.D., Chairman of the Committee on Mental Health and the Physician Effectiveness Program. “Ideally, we will intercept the problem before it requires action by the Ohio State Medical Board on the physician’s license.”

The subcommittee bases its three-tiered action program on six general principles:

1. We should be motivated by humanitarian concerns for the public and the impaired physician.
2. We should recognize that alcoholism, drug abuse, and mental illness among physicians are too often ignored or untreated.
3. We should recognize that alcoholism, drug abuse, and mental illness are treatable conditions—and that treatment and rehabilitation personnel skilled in these areas have a good success record.
4. We should encourage all impaired physicians to seek help and cooperate in treatment at the earliest possible time in order for them to retain or regain full effectiveness to practice.
5. We should employ *constructive coercion* if a physician refuses all offers for assistance at a time when his impairment poses a threat to reasonable delivery of medical care.
6. We should employ *involuntary coercion* where all efforts fail—and the physician’s impairment threatens the public or physician’s health.

A detailed, step-by-step description of the program follows. Basically, it calls for an initial telephone call to the appropriate OSMA staff person from a physician who realizes he or she has a problem. The impaired physician will then be contacted by the respective District Liaison Physician (DLP), a member of the Committee on Mental Health practicing in the same councilor dis-

trict. The DLP will discuss the problem with the physician and encourage him or her to seek appropriate counseling or treatment.

Anyone seeking assistance, or peers seeking assistance for colleagues, may initiate the program by telephoning (614) 228-6971 and asking for the Physician Effectiveness staff person.

Each county medical society and hospital staff is encouraged to consider a similar program at the local level. However, the physician’s desire for confidentiality regarding his peers, patients, and friends in the community often makes the program more desirable at the state level.

As practitioners of the healing arts, physicians more than any other professional group should be prepared to help troubled colleagues. Individual physicians and organized medicine must recognize and exercise their responsibility to provide the highest quality of medical care to all patients.

Option I

When the disabled physician himself seeks guidance and referral through OSMA, the following sequence of events should be undertaken:

1. The disabled physician telephones (614) 228-6971 and gives his name, address, and telephone number to the staff member working with the Physician Effectiveness Program. The physician indicates his desire for medical help.
2. The staff member contacts the respective District Liaison Physician (DLP).
3. The DLP contacts the physician, inquiries about the nature of his illness or problem, and discusses appropriate evaluation and treatment arrangements.
4. The DLP contacts the psychiatrist or other physician considered most appropriate to care for the disabled physician and discusses the general nature of the problem.
5. The disabled physician enters treatment with the attending physician, ending OSMA’s involvement.

Option II

The option also exists for a concerned peer (another physician practicing in the same community) to inform OSMA that a fellow physician might be ill and in need of assistance. In this case, the following sequence of events results:

1. The concerned peer calls the OSMA Physician Effectiveness Program (614/228-6971) giving his own name, address, and telephone number; the name, address, and telephone number of the colleague whose mental health is considered questionable; and the specific reasons for concern. The initiating physician will be

guaranteed subsequent anonymity, although he will be required to identify himself to assure that he is indeed a physician. This minimizes the risk of frivolous or vindictive calls.

2. The Physician Effectiveness staff member contacts the respective DLP.

3. The DLP checks with the appropriate individual or committee of the local County Medical Society to determine whether, in the society's judgment, there is sufficient reason to believe the physician in question is ill. This does not require any initiative on the part of the County Medical Society, but simply confirmation from it that other physicians share the concern that this particular colleague might be ill.

4. The DLP reports to the Chairman of the Physician Effectiveness Program that sufficient cause exists to justify contacting the physician thought to be ill.

5. The chairman writes to the physician, explaining the nature of OSMA's program, the general circumstances leading to his letter (preserving anonymity for all individuals involved), and urging the physician to seek appropriate evaluation and treatment. This letter also indicates that the DLP will contact the physician personally to make appropriate arrangements.

6. The DLP contacts the disabled physician and offers to help if any problem exists.

7. If the physician in question acknowledges his illness and need for assistance, the DLP then makes arrangements with an attending physician to evaluate and treat him.

8. The disabled physician then enters treatment as agreed between himself and the attending physician.

9. The only further contact between the attending physician and the DLP is the former's confirmation that the disabled physician is indeed undergoing appropriate treatment.

10. The DLP reports to the chairman that no further action on OSMA's part is indicated. Thus, no contact is made with the Ohio State Medical Board.

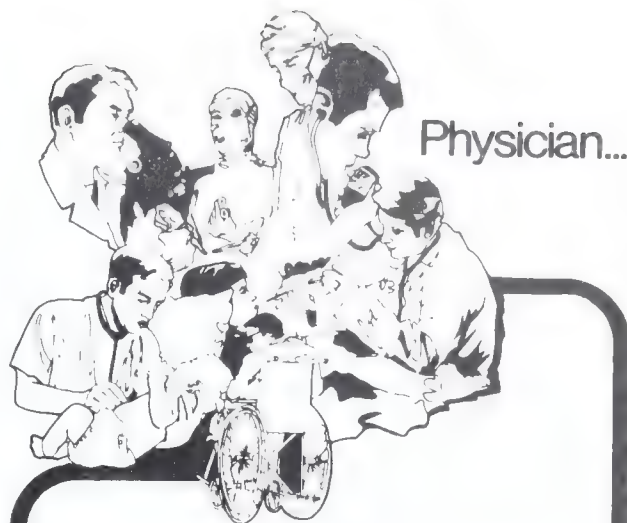
Option III

In some cases, the physician whose health is in question may deny any illness and refuse suggestions of evaluation or offers of treatment. Under these circumstances, the following sequence of events would occur:

1. The concerned peer calls the OSMA Physician Effectiveness Program (614/228-6971) giving his own name, address, and telephone number; the name, address, and telephone number of the colleague whose mental health is considered questionable; and the specific reasons for concern. The initiating physician will be guaranteed subsequent anonymity, although he will be required to identify himself to assure that he is indeed a physician. This minimizes the risk of frivolous or vindictive calls.

2. The Physician Effectiveness staff member contacts the respective DLP.

(continued on page 189)



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A regular meeting of the Council of the Ohio State Medical Association was held Saturday, January 31, and Sunday, February 1, 1976, at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Drs. James L. Henry and William Dorner, Jr.); James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; John H. Budd, M.D., Cleveland, member of the AMA Board of Trustees; Mr. D. Mark Mahler, Columbus, Ohio State University American Medical Student Association representative; Henry G. Cramblett, M.D., Dean, Ohio State University College of Medicine; John H. Wulsin, M.D., Dean for Administration, University of Cincinnati College of Medicine; Frederick C. Robbins, M.D., Dean, Case Western Reserve University School of Medicine; John R. Kempf, M.D., Dean, Medical College of Ohio at Toledo; Stanley W. Olson, M.D., Dean, Northeastern Ohio Universities College of Medicine; John R. Beljan, M.D., Dean, Wright State University School of Medicine; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Mulgrew, Holcomb, Freeman, Mrs. Wisse, Mrs. Dodson, Ms. Doll and Mrs. Jacobson of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Drs. Henry, Dorner and Robert G. Thomas); Dr. Budd; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Mulgrew, Holcomb, Freeman, Mrs. Wisse and Mrs. Dodson, of the OSMA Staff.

The meeting was called to order by President Lieber.

The minutes of the December 13-14, 1975 meeting of the Council were approved.



Left to right: Frederick C. Robbins, M.D., Dean, Case Western Reserve University School of Medicine; George Bates, M.D.; Maurice F. Lieber, M.D.

MEMBERSHIP

The membership report was presented by Mrs. Wisse and was accepted for information.

Legal Counsel presented an opinion on citizenship as a requirement for membership in the Association. The Council directed that the opinion be filed with the appropriate reference committee at the Annual Meeting.

By official action, the Council **adopted** the following resolution for presentation to the OSMA House of Delegates in May, 1976:

RESOLVED, that Chapter 1, Section 3, line 2 be amended to provide as follows: "after 'honorary' insert 'faculty.'"

RESOLVED, that Chapter 1, Section 3(b) of the Bylaws be amended to provide as follows:

(b) He must hold a limited, temporary, or unlimited certificate to practice medicine and surgery, or osteopathic medicine and surgery, issued by the licensing authority of the State of Ohio, which license must be in full force and effect at the time of his application for membership in this Association, or he must hold an unlimited and unrestricted license or certificate to practice medicine and surgery in any state of the United States of America, or he must be a full-time faculty member holding a degree of doctor of medicine or doctor of osteopathic medicine and surgery at an accredited college of medicine or an accredited college of osteopathic medicine and surgery.

FISCAL MATTERS

The minutes of a meeting of the Committee on Auditing and Appropriations held January 30, 1976, were reported by Dr. Thomas. By official action, the minutes were **approved** as presented.

AMERICAN MEDICAL ASSOCIATIONS

The 1976 American Medical Association Leadership Conference was reviewed, receiving high ratings from those who attended.

Robert M. Zollinger, M.D., Columbus, was nominated for the 1976 AMA Sheen award by the Council, on behalf of the Ohio State Medical Association.

SPLINTER ORGANIZATIONS

With regard to a communication concerning unionization of physicians, the Council **adopted** the following statement:

"The federation of medicine has the wherewithal to accomplish all the goals espoused by the various 'splinter organizations.' It is only necessary that county medical societies, state associations, specialty societies, the American Medical Association, and the members of these organizations stand together in an advocacy role for medicine."

ANNUAL MEETING

A progress report on the 1976 Annual Meeting was presented by Mrs. Dodson.

(continued on page 172)

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ease, dehydration, heat cramps and hyperkalemia.

Warnings: Do not use excessively.

Precautions: Administer with caution and adjust to the requirements of the individual patient. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis. ***Patients should be cautioned to adhere to dilution instructions.***

Adverse Reactions: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs,

flaccid paralysis, fall in blood pressure, cardiac depression, arrhythmias, arrest and heartblock. Vomiting, nausea, abdominal discomfort and diarrhea may occur.

Dosage and Administration:

One 15 ml. tablespoonful (20 meq. of potassium chloride) ***diluted*** in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician.

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3785 ml. . . . NDC 0041-0145-28



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential

status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.



Pharmaceutical Manufacturers
Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

By official action, the Council voted to designate the Sheraton Cleveland Hotel, in Cleveland, Ohio, as the site of the 1978 Annual Meeting.

OHIO MEDICAL INDEMNITY, INC.

A report of the December 17, 1975, meeting of the Executive Committee of Ohio Medical Indemnity, Inc., was presented by Mr. Page.

OHIO FOUNDATION FOR MEDICAL CARE

A report on the January 28, 1976, meeting of the Board of Directors of the Ohio Foundation for Medical Care was presented by Dr. Porterfield.

The following proposal was submitted by Dr. Porterfield:

The triad of current health care issues are: (1) the appropriate delivery of health care, (2) the accessibility of health care, (3) the control of health care costs.

The health care insurance industry is designed to provide a reimbursement mechanism and must by nature be primarily concerned with cost containment.

Government is concerned with all of the issues because of the major impact that health care and its cost have on the economy—a 100+ billion dollar industry of which more than 1/3 is directly supported by Federal dollars. Thus the legislation in recent years, i.e., Medicare, Medicaid, HMO's, etc.

The patient desires accessibility to quality care at the lowest possible cost.

Medicine likewise is primarily interested in the quality of care, its availability and its delivery at the lowest possible cost. Medicine also feels that the patient is best served when

he is free to select his physician and when the service is performed on a fee for service basis.

In order to avoid governmental takeover of both the health insurance industry and the medical profession which would also include all of the health care facilities, i.e., hospitals, etc., physicians must be willing to influence the dollar support system (health insurance industry) sufficiently to impact the cost containment problem while still offering quality service in the most available manner.

Question—Is medicine prepared to participate in the design of the health care package, is it prepared to insure its successful implementation by actively aiding in cost containment in order to assure its success? This success can only be assured by the appropriate utilization of outpatient care, strengthening the utilization review in hospitals, increasing the use of preadmission testing and work-ups, greatly increasing the use of home health care plus many other potentially effective means.

Question—Is the health insurance industry prepared to share the responsibilities of the design of the health care package and its management with physicians who by having a role in this design will be willing to assume equal responsibilities for its success?

Question—Isn't the participation directly by physicians in the reimbursement mechanism necessary to assure its success?

Since OFMC is charged with the responsibility of developing alternative methods of health care delivery in the State by the OSMA House of Delegates, shouldn't OFMC be the prime coordinator of any effort to achieve the previously described goals. If so, shouldn't OFMC enter into appropriate discussions with representatives of the health care industry with the approval of the OSMA Council and work towards the development of such programs.

★

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The Council directed that the President appoint an *ad hoc* committee to study the proposal (Dr. Pichette dissenting).

Dr. Lieber appointed Dr. Thomas (Chairman), Dr. Bates, Dr. Henry and Dr. Morgan to the *ad hoc* committee.

COMMITTEE REPORTS

COMMISSION ON MEDICAL EDUCATION

Minutes of the January 14, 1976, meeting of the Commission on Medical Education were presented by Mrs. Dodson.

A new manual for Ohio Continuing Medical Education accreditation (institutional), developed by the Commission, **was approved**.

A suggestion that the Commission cosponsor a symposium of the Medical Educators' Association, to be held in Cleveland, March 13, 1976, **was approved**.

The concept of a screening committee to review (institutional) requests for accreditation **was approved**.

The Council **approved** the Commission's recommendations for Recognition Awards for 23 physicians and for accreditation of two institutions.

The minutes as a whole **were approved**.

COMMITTEE ON MATERNAL HEALTH

Minutes of a meeting of the Committee on Maternal Health, held January 17-18, 1976, were reported by Mrs. Dodson.

The Council **approved** a change in the designation of the Committee to "The Committee on Maternal and Neonatal Health;" expansion to include a pediatrician and a neonatologist; and the appointment of a steering committee to develop objectives and perimeters of the newly expanded committee.

The minutes as a whole **were approved**.

AD HOC COMMITTEE TO STUDY COMPLAINT PROCEDURES

The minutes of the November 5, 1975, meeting of the Ad Hoc Committee to Study Complaint Procedures were brought up for reconsideration.

It was pointed out by Mr. Gillen that there was an error in reference to the discussion of "Usual, Customary and Reasonable." The Council **approved** the deletion of the definitions in the Committee's minutes.

PHYSICIAN EFFECTIVENESS SUBCOMMITTEE

Mr. Clinger reported on the work of the Physician Effectiveness Subcommittee.

COUNCILOR REPORTS

The Councilors reported on various activities in their respective districts and discussed grievance and professional liability matters therein.

FEDERAL LEGISLATION

Mr. Edgar reported on new developments in Federal Legislation.



Left to right: John C. Smithson, M.D.; C. Edward Pichette, M.D.; John R. Beljan, M.D., Dean, Wright State University School of Medicine; W. J. Lewis, M.D.

The Council **adopted** as OSMA policy, the AMA position on HMO legislation. This position is that current HMO legislation should not be amended to delete required services and benefits in relation to preventive medicine and health maintenance.

STATE LEGISLATION

Mr. Rader reported, and the Council discussed and **adopted** policy on the following legislation pending in the Ohio General Assembly.

Senate Bill 149, to extend tax collection functions to state professional licensing boards—**opposition**.

House Bill 136, to remove exemption from jury duty for various professions, including medicine—**opposition**.

House Bill 1000, to make mandatory the offering of Pap tests to female in-patients over age 20—**opposition to mandatory aspects of the bill**.

House Bill 1215, mental health—referred to Committee on Mental Health.

House Bill 1227, occupational therapy licensing—referred to Health Manpower Committee.

House Bill 1235, living will—referred to Transplant Committee.

Substitute House Bill 832, liability of emergency medical technicians—ambulance and of physicians advising them—**support**.

The Council voted to encourage the State Medical Board to **continue** publication of "The Roster of Registered Physicians in the State of Ohio."

CONSTITUTION AND BYLAWS

Amendments to the Constitution and Bylaws of the Monroe County Medical Society **were approved**.

LEGAL COUNSEL REPORT

Mr. Pohlman reported on recent developments in the lawsuit filed by the Attorney General of Ohio against OSMA and Ohio Medical Indemnity, Inc.

(continued on page 174)

The Council directed that a special message to the members from the President with regard to the status of the lawsuit be issued as a special issue of the *OSMAgram*.

The professional liability situation was discussed, including forthcoming rate filings by "ISO" (Insurance Service Organization) which represents most companies writing professional liability insurance other than Medical Protective, Inc.

Legal Counsel also advised that he had been in touch with OSMA's consulting actuaries in anticipation of formulating OSMA's response to the "ISO" filings.

ARBITRATION

Mr. Mulgrew announced that forms for voluntary, binding arbitration would be ready for distribution by June 1, 1976, in four pilot projects in Ohio.

A motion to adopt recommendations on voluntary, binding arbitration was passed.

It will involve initiation of pilot projects of hospital based voluntary, binding arbitration systems subsequent to the Ohio Hospital Association Annual Meeting in April.



Left to right: Stanley W. Olson, M.D., Dean, Northeastern Ohio Universities College of Medicine; Henry G. Cramblett, M.D., Dean, The Ohio State University College of Medicine; Richard E. Hartle, M.D.; John H. Wulsin, M.D., Dean for Administration, University of Cincinnati College of Medicine.

CONSENT FORMS

The Council adopted the following statement on "informed consent agreements":

Utilization of a form meeting the statutory requirements of Section 2317.54 (A), (B), and (C) in H.B. 682 creates only a presumption of validity. Since significant difficulties have been encountered by physicians utilizing statutory form (D) in their practice, it is the recommendation of the Ohio State Medical Association that the individual practitioner decide with advice from his personal counsel which, if any, informed consent form he should use in his own practice. The OSMA will not sanction or encourage the use of a single informed consent form for statewide use. The members are further advised to bear in mind that the use of any informed consent form only documents a disclosure of pertinent information by the physician to the patient and does not relieve the physician of the responsibility of making the disclosure of that information to the patient.

The OSMA Department of State Legislation was asked by the Council to prepare an article on informed consent for publication in the *OSMA Journal*.

ADVERTISING

A question on advertising of medical services was referred to the Committee on Judicial and Professional Relations.

HEALTH SERVICE AGENCIES

By official action, the Council voted to protest the inadequate representation of practicing physicians on Boards of Directors of Health Service Agencies.

CHAMPUS PROGRAM

Mr. Gillen reported that CHAMPUS (program for military dependents and military retirees) has announced

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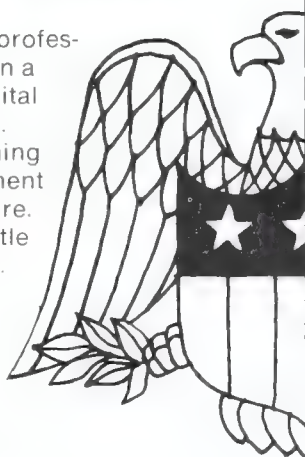
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reduction in payments to physicians for services rendered under the program to the 75th percentile of 1974 charges. Reduction was effective January 1, 1976. CHAMPUS formerly paid at the 90th percentile updated every six months.

It was pointed out that physicians may avoid the problems by direct billing of the patients under this program.

It was announced that Dr. Lieber has communicated with the Department of Defense with regard to the above changes in the system.

FIELD SERVICE REPORT

Mr. Holcomb reported on plans and activities of the Department of Field Service.

SEMINAR ON UTILIZATION REVIEW

The Council **approved** cosponsorship with the Ohio Hospital Association of a Joint Commission on Accreditation Seminar on Utilization Review.

CONFERENCE WITH DEANS

Saturday afternoon, January 31, was devoted to a conference with the deans of Ohio's six medical schools.

The discussion opened with a review of Health Manpower legislation, both State and Federal.

Entering medical classes in 1976 will include 112 at Medical College of Ohio at Toledo; 138 at Case Western Reserve School of Medicine; 32 at Wright State; 227 at Ohio State University; 192 at the University of Cincinnati. It was predicted that 42 will be accepted at the Northeastern Ohio Universities in the fall of 1977.

The next issue studied was the Health Systems Agency of the Health Service Area and its potential effect on medical schools and on the practice of medicine.

Continuing medical education requirements for physicians under Ohio law were reviewed, and the medical schools indicated that they were ready and anxious to provide quality opportunities to Ohio physicians in post-graduate education. It was pointed out that these efforts must be self-supporting, since budgets for production of M.D. graduates are already a problem.



Left to right: John J. Gaughan, M.D.; Robert G. Thomas, M.D.; John H. Budd, M.D., Cleveland, member of the AMA Board of Trustees; John R. Kempf, M.D., Dean, Medical College of Ohio at Toledo.

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Problems faced by medical schools in dealing with professional liability problems involving students and staff personnel were discussed. Dr. Beljan noted that these problems were especially critical for newly established institutions.

The growing legislative interest in mandating decisions which should be professional in nature was reviewed, especially with regard to the violation of relationships between State Institutions and State Government, wherein parochial interests interfere with broad principles.

An anticipated crisis, developing due to the production of more students without a parallel increase in internships and residencies was evaluated by the conference. The deans cited insufficient funding as the major roadblock to developing residency programs in Ohio's community hospitals.

CANDIDATES ANNOUNCED

Dr. Lieber announced that a communication has been received from the Cincinnati Academy of Medicine nominating Dr. Hogg for president-elect, and that a similar communication has been received from the Licking County Medical Society, nominating Dr. Wells for the office of president-elect.

The next meeting of the Council is March 13-14. AMA delegation to meet on the evening of March 12.

ATTEST: Hart F. Page
Executive Director



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1976 Annual Meeting Update

Gail Dodson, OSMA Convention Coordinator

Program Entitled "Rape: Victim and Offender" Highlight of Annual Meeting

One of the highlights of the Annual Meeting is the program on "Rape: Victim and Offender" scheduled for Monday, May 10, at 1 PM in the Cincinnati Exposition Center. Participants in this program are A. Nicholas Groth, Ph.D., and Ann Wolbert Burgess, R.N., D.N.Sc., both of Massachusetts.

The discussants will cover the mythological aspects of rape which are countered by clinical research, patterns of rape, diagnosis of the aggressive sexual offender, counseling implications for the rape victim, and treatment of the aggressive sexual offender.

For the past ten years, Dr. Groth, a graduate of Boston University, has been involved in the diagnostic assessment and treatment of convicted rapists and child offenders as Chief Psychologist at the Massachusetts Treatment Center for Sexually Dangerous Persons. He is consultant to the Massachusetts Criminal Justice Training Council and holds teaching appointments at Northeastern University and Simmons College in Boston.

Dr. Burgess is a nurse-psychotherapist and researcher in crisis intervention and victimology at Boston College. Her research with rape victims was carried out while she was a victim counselor at the Boston City Hospital Emergency Floor.

OSMA Committee on Scientific Work Designs CME Courses

Category I Continuing Medical Education courses will be offered at the 1976 Annual Meeting. The following courses, which can be applied toward the OSMA and AMA Physician's Recognition Awards, are each eligible for three hours Category I credit and have been designed by the OSMA Committee on Scientific Work. The courses will be held from 7:30 AM to 9 AM beginning on Tuesday, May 11, and continuing on Wednesday, May 12, on the upper level of the Cincinnati Convention Center.

COURSE ONE: "Clinical Management of Electrolyte and Acid Base Disturbances"; Tuesday, May 11: Clinical Problems in Acid Base Balance; Wednesday, May 12: Clinical Problems of Sodium and Water Metabolism.

Course Directors: Lionel R. King, M.D., Associate Clinical Professor of Medicine, University of Cincinnati College of Medicine; Director, Hemodialysis Unit, Good Samaritan Hospital, Cincinnati. E. Gordon Margolin, M.D., Director of Department of Internal Medicine of

Cincinnati Jewish Hospital and Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati.

The purpose of the course is to enable the participant to become familiar with the normal anatomy of body fluid and electrolyte compartments and the terminology of fluid, electrolyte, and acid-base disturbances. In addition, he will be taught to recognize and define common clinical problems of acid-base disturbance from blood pH, pCO₂, and bicarbonate determinations and to understand derangements in and approaches to sodium and water syndromes.

COURSE TWO: "Principles of Electrocardiology"; Tuesday, May 11, and Wednesday, May 12.

Course Director: Donald C. Fischer, M.D., Medical Director, Good Samaritan Hospital, Cincinnati.

The objectives of this course are two: first, to review the principles of electrophysiology as they are manifested in the routinely recorded 12-lead electrocardiogram; and second, to review in detail several of the major problem areas of ECG interpretation—namely, the ventricular conduction disturbances (bundle branch blocks), the arrhythmias of common concern in the CCU-ICU areas, and the ECG abnormalities seen with pulmonary emboli and pericarditis.

COURSE THREE: "Chemotherapy of Infections"; Tuesday, May 11, and Wednesday, May 12.

Course Director: Gilbert M. Schiff, M.D., Director, Division of Infectious Diseases, University of Cincinnati.

The session will be divided into two parts. Part 1 will discuss the choice of antibiotics particularly regarding the new aminoglycosides and cephalosporins. Part 2 will discuss the present status of antiviral therapy.

COURSE FOUR: "Diagnosis and Plan of Management of Common Vascular Problems"; Tuesday, May 11, and Wednesday, May 12.

Course Director: John J. Cranley, M.D., Director of Surgery and Director of Medical Education, Good Samaritan Hospital, Cincinnati; and Assistant Clinical Professor of Surgery, University of Cincinnati.

Common clinical problems will be reviewed with emphasis on diagnosis and management. The first session will cover arterial trauma, emboli, aneurysms, A-V fistulae, obliterative arterial disease, cerebrovascular insufficiency, neurovascular compression syndromes, and Raynaud's phenomenon. The second session will review newer noninvasive techniques for establishing the diagnosis of thrombophlebitis and venous thrombosis and differentiating between other lower extremity disorders. It will include current prophylaxis and treatment of pulmonary embolism, and of chronic venous insufficiency, with and without ulceration.

(continued on page 178)

Annual Meeting Update *(continued)*

COURSE FIVE: "Noninvasive Diagnosis of Cardiovascular Disease"; Tuesday, May 11, and Wednesday, May 12.

Course Director: John C. Holmes, M.D., Professor of Medicine, Associate Professor Radiology, Director, Cardiac Catheterization Laboratory, University of Cincinnati.

The panel will illustrate the value of noninvasive techniques in diagnosis of common heart problems. Appropriate basic information will be examined, but major emphasis will be placed on practical clinical aspects and recent advances. Topics include: clues to diagnosis from inspection, phonocardiography, echocardiography, stress electrocardiography, and myocardial imaging with radioisotopes.

COURSE SIX: "Sexual Counseling"; Tuesday, May 11, and Wednesday, May 12.

Course Director: Elizabeth Wales, Ph.D., Department of Psychology, University of Cincinnati.

This course will focus on: sexual problems frequently encountered in medical practice, the role of the physician as a sexual authority, and commonly experienced difficulties in doing sexual counseling. Ethics, values, and moral issues from both the patient and the physi-

cian's viewpoint will be discussed. The purpose of these discussions will be to highlight hidden issues in sexual counseling in order to increase comfort and competency in sexual advising.

COURSE SEVEN: "Business Management in the Doctor's Office," Tuesday, May 11, and Wednesday, May 12.

Course Director: Robert G. Rothring, President, Professional Management Service, Cincinnati.

The course will outline basic office procedures and policies with regard to employees, patients, and other persons directly connected with the physician's practice. It will cover records that are required to be kept by law, internal controls, and what the physician can expect from his accountant. The course will also cover the tax aspects of incorporation, Keogh plans, and tax shelters.

COURSE EIGHT: "Chronic Obstructive Pulmonary Disease"; Tuesday, May 11, and Wednesday, May 12.

Course Director: Robert G. Loudon, M.B., Ch.B., Director, Pulmonary Disease Division, University of Cincinnati.

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COURSE NINE: "Office Management of Headaches"; Tuesday, May 11, and Wednesday, May 12.

Course Director: Robert Smith, M.D., Professor and Director, Department of Family Medicine, University of Cincinnati.

The course will be devoted to the common problems concerned with the office management of headaches. This will include techniques for evaluation of different types of headaches and appropriate treatment. The first session, Tuesday, May 11, will be devoted to some general comments by the course director, Dr. Robert Smith, on the problems of interpreting pain as a symptom. The first session will devote itself particularly to the management of headaches in adults (by Dr. Charles Aring); and the second session, Wednesday, May 12, will be devoted to the management of headaches in children (by Dr. Samuel Shelburne).

REGISTRATION FORM: POSTGRADUATE COURSES

Registration Fee: \$15.00 per course
(fee includes continental breakfast)

Courses scheduled on Tuesday, May 11, and continued on Wednesday, May 12, from 7:30 AM to 9 AM.

Please register me for COURSE NUMBER _____

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*(Annual Meeting Update
continued on page 180)*

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Ohio Neurosurgical Society To Honor Frank Mayfield, M.D.

The Ohio State Neurosurgical Society has chosen the 1976 Annual Meeting as a time to honor Frank H. Mayfield, M.D., F.A.C.S. On Monday, May 10, the society will host a banquet in Dr. Mayfield's honor at the Queen City Club beginning at 7 PM.

Dr. Mayfield, who is Clinical Professor of Surgery (Neurosurgery) at the University of Cincinnati College of Medicine and Director, Department of Neurosurgery, at Good Samaritan and Christ Hospitals, will continue to be honored on Tuesday, May 11, by an all-day symposium. This program is entitled "Symposium on Disorders of the Cervical Spine."

The schedule for the Ohio State Neurosurgical Society's symposium is as follows:

8 AM Welcome: Robert White, M.D., Cleveland, President Ohio State Neurosurgical Society.

Introduction of Frank H. Mayfield, M.D., Honored Neurosurgeon.

"Cervical Spondylosis — Etiology and Treatment"

8:30 AM "The Neurological Syndromes of the Extruded Cervical Disc with Emphasis on the Posterior Approach to These Lesions"—Francis Murphey, M.D., Chief of Neurosurgery Service, Baptist Memorial Hospital and City of Memphis Hospitals, Naples, Florida.

9 AM "Herniated Cervical Disc—Techniques of Surgical Treatment"—William Scoville, M.D., Clinical Professor of Neurosurgery, Yale University College of Medicine, New Haven, Connecticut.

9:30 AM "The Hydrodynamic Mechanism of Post-Traumatic Syringomyelia"—James Gardner, M.D., Director Emeritus, Department of Neurosurgery, Cleveland Clinic, Cleveland.

10 AM Break.

10:30 AM "Posterior Fusion of Cervical Spine in Fractures and Dislocations"—Eben Alexander, M.D., Professor of Neurosurgery, Bowman Gray School of Medicine, Winston-Salem, North Carolina.

11 AM "Treatment of Odontoid Fractures"—Robert McLaurin, M.D., Division of Neurosurgery, Cincinnati General Hospital, Cincinnati.

11:30 AM "Atlanto-Axial Dislocation in Childhood"—Michael McWhorter, M.D., Cincinnati.

11:45 AM "Biomechanics of the Cervical Spine"—Stewart Dunsker, M.D., Cincinnati.

12 Noon Discussion.

1 PM Luncheon at the Banker's Club, Cincinnati, Presiding Officer: Robert White, M.D., Cleveland, President, Ohio State Neurosurgical Society.

2 PM "Computerized Axial Tomography in Neurologic Diagnosis"—Robert Lukin, M.D., Associate Professor of Radiology and Chief of Neuroradiology,

University of Cincinnati Medical Center, Cincinnati.

2:30 PM "Recent Concepts in Head Injury Management"—Robert White, M.D., Cleveland.

3 PM "Chemotherapy of Brain Tumors"—William Hunt, M.D., Professor and Director of the Division of Neurological Surgery, Ohio State University, Columbus.

3:30 PM Break.

Presiding Officer: William Hegarty, M.D., President-Elect, Ohio State Neurosurgical Society.

4 PM "Cerebral Revascularization"—John M. Tew, Jr., M.D., Secretary, Ohio State Neurosurgical Society.

4:30 PM "Recent Advances in Spinal Cord Injury Research"—David Yashon, M.D., Treasurer, Ohio State Neurosurgical Society.

5 PM Business Meeting.

Robert D. Novak Repeat Performer as OMPAC Speaker

The Ohio Medical Political Action Committee (OMPAC) speaker at the Annual Meeting is Robert D. Novak. Mr. Novak, a Washington, D.C. columnist who writes the syndicated column "Inside Report" published in more than 250 newspapers in the United States and abroad, has been the OMPAC speaker in previous years. He will deliver his address at a noon luncheon on Tuesday, May 11.

Mr. Novak and his coauthor, Rowland Evans, Jr., give appraisals from behind the scenes of significant and unexpected developments on national, state, and local trends as well as cover the international scene. Robert Novak is often described as a news-hungry journalist who specializes in investigation and probing analysis instead of armchair commentary.

(continued on page 182)



Robert D. Novak

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Rooms will be held until 6:00 P.M. unless payment is guaranteed.

Annual Meeting Update (continued)

A graduate of the University of Illinois, Mr. Novak began his newspaper career in his hometown on the Joliet *Herald News*. After serving as a lieutenant in the Korean War, he joined the Associated Press Omaha office and later continued with the news service in Lincoln, Nebraska, and Indianapolis. In 1957, he went to Washington as Capitol Hill Correspondent for the Associated Press and transferred to *The Wall Street Journal* in 1958 as Senate correspondent and political reporter. Later he became their Chief Congressional Correspondent.

Since 1963, he and Mr. Evans have been writing "Inside Report" and a biweekly newsletter, "Evans-Novak Political Report." Mr. Novak also has written *The Agony of the G.O.P.* (1964), and coauthored with Mr. Evans *Lyndon B. Johnson: The Exercise of Power* (1966) and *Nixon in the White House* (1971).

Many Organizations Contribute To Annual Meeting Program

SATURDAY, MAY 8

The OSMA Section on Psychiatry and Neurology and the Ohio Psychiatric Association (OPA) will lead off the Annual Meeting on Saturday, May 8, by sponsoring the following program:

- 4 PM OPA Foundation, Stouffers Cincinnati Inn, Cabana A Room.
- 5 PM OPA Council Meeting, Stouffers Cincinnati Inn, Bamboo A Room.
- 6:30 PM OPA Council Dinner, Stouffers Cincinnati Inn, Bamboo B Room.
- 8 PM Continuation of OPA Council Meeting, Stouffers Cincinnati Inn, Bamboo A Room.

SUNDAY, MAY 9

A program on "Current Concepts of Treatment in Psychosomatic Medicine," sponsored by the Section on Psychiatry and Neurology and the Ohio Psychiatric Association, will be held at the Emerson A. North Hospital, 5642 Hamilton Avenue, Cincinnati. Transportation will be provided from the hotels to the hospital. The program is as follows:

- 1-2 PM "Clinical Biofeedback: Behavioral Medicine"—Bernard T. Engel, Ph.D., Chief, Laboratory of Behavioral Sciences, Gerontology Research Center, National Institute on Aging; Associate Professor, Behavioral Biology, Johns Hopkins University, Baltimore, Maryland.
- 2-3 PM "Transcendental Meditation"—Harold Bloomfield, M.D., Institute for Psychophysiological Medicine, San Diego, California.
- 3-4 PM "Behavior Modification Techniques"—Stewart Agras, M.D., Stanford University, Palo Alto, California.
- 4-5 PM "Psychotherapy"—Robert Kelner, M.D., Ph.D., University of New Mexico School of Medicine, Albuquerque, New Mexico.
- 5-6 PM Panel Discussion: Drs. Engel, Benson, Agras, and Kelner.

MONDAY, MAY 10

The following program is Part 1 of a two-day program sponsored by the OSMA Section on Otolaryngology and the Ohio Society of Otolaryngology. Daniel Lavigna, M.D., Columbus, Secretary and Program Chairman, Ohio Society of Otolaryngology, will preside.

- 9 AM "Evaluation and Treatment of Sinus Disease"—Charles S. Blase, M.D., Cincinnati, President, Ohio Society of Otolaryngology.
- 10 AM "Medical Treatment of Chronic Ear Infection"—Daniel M. Lavigna, Jr., M.D., Columbus.
- 11 AM "The Dizzy Patient"—Edward L. Hendershot, M.D., Cleveland.

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MONDAY, MAY 10

The following is the program sponsored by the Ohio State Medical Association Section on Neurology. The Course Director is George W. Paulson, M.D., Columbus, Program Chairman, Section on Neurology.

- 1:30-2:15 PM **"Neurology of Sleep"**—H. Richard Tyler, M.D., Professor of Neurology, Harvard Medical School, Boston, Massachusetts.
- 2:15-2:45 PM **"Brain Death"**—J. Norman Allen, M.D., Director of the Division of Neurology, Professor of the Department of Medicine and Professor of the Department of Physiological Chemistry, Ohio State University, Columbus.
- 2:45-3:15 PM **"Acoustic Detection of Intracranial Aneurysms"**—Charles P. Olinger, M.D., Director of the Stroke Research Lab and Associate Professor of Neurology, Cincinnati; and Jack F. Wasserman, Ph.D., Cincinnati. Dr. Olinger and Dr. Wasserman have developed a noninvasive acoustic technique for the detection of intracranial aneurysms.
- 3:15-3:45 PM **"Nerves, Brains and Buckeyes"**—Joseph M. Foley, M.D., Sc.D., Professor of Neurology, Case Western Reserve University; Director, Division of Neurology, University Hospitals of Cleveland.
- 3:45-4:15 PM **"Muscle Advances"**—Jerry Mendell, M.D., Associate Professor of the Department of Medicine, Ohio State University, Columbus.
- 4:15 PM Business meeting

TUESDAY, MAY 11

A program entitled **"Environment and Pulmonary Pathology"** and sponsored by the OSMA Section on Pathology and the Ohio Society of Pathologists will feature John P. Wyatt, M.D., as the out-of-state guest speaker. Dr. Wyatt has had a long-time interest in reactions of lung to injury in particular infectious, physical, and chemical injuries and their particular effect in producing distinctive lung diseases and associated alterations in lung function. The President is Brian S. Harrold, M.D., Canton, and the Course Director is Edward A. Gall, M.D., Cincinnati.

- 9-9:30 AM **"General Principles of Environmental Pathology: Reflections from the Lung"**—John P. Wyatt, M.D., Professor of Pathology, University of Kentucky and Director, University of Kentucky Tobacco and Health Research Institute, Lexington, Kentucky.
- 9:30-10 AM **"Diagnostic Approaches in Pulmonary Diseases"**—Robert G. Loudon, M.B., Ch.B., Professor of Medicine and Director, Pulmonary Disease Division, Department of Internal Medicine, University of Cincinnati.
- 10-10:30 AM **"An Approach to Occupational Lung Diseases for Medical Practitioners"**—Stuart M. Brooks, M.D., Associate Professor of Internal Medicine and Environmental Health; Chief, Clinical Studies Division, Department of Environmental

Health, University of Cincinnati College of Medicine.

- 10:30-10:45 AM Tour of Exhibits.
- 10:45-11:15 AM **"Pulmonary Dust Diseases"**—Benjamin Felson, M.D., Professor of Radiology, University of Cincinnati College of Medicine.
- 11:15-11:45 AM **"Low-Level, Long-Term Effects of Auto Exhaust & Other Pollutants in Beagles"**—Jerry F. Stara, D.V.M., M.P.H., M.S., Acting Director, Toxicology Division, Health Research Laboratory, U.S. Environmental Protection Agency; and Assistant Clinical Professor of Radiology and Environmental Health, University of Cincinnati.
- 12-12:30 PM Business Meeting.
- 2-5 PM Slide Seminar.

TUESDAY, MAY 11

The following program is Part 2 of a two-day program sponsored by the OSMA Section on Otolaryngology and the Ohio Society of Otolaryngologists. Daniel Lavigna, M.D., Secretary and Program Chairman of the Ohio Society of Otolaryngologists, will preside.

- 9 AM **"Dynamics of Rhinoplasty"**—M. Eugene Tardy, M.D., Associate Professor of Otolaryngology, University of Illinois; and Executive Secretary, American Academy of Facial Plastic and Reconstructive Surgery, Oak Park, Illinois.
- 9:45 AM **"Rhinoplasty Potpourri"**—Trent W. Smith, M.D., Columbus, Past President of the American Academy of Facial Plastic and Reconstructive Surgery. Dr. Smith is a national and international lecturer and surgical demonstrator in his field.
- 10:45 AM **"Pedical Flap Repair in Head & Neck Reconstruction"**—M. Eugene Tardy, M.D., Oak Park, Illinois.
- 11:30 AM Question and Answer Period: Discussant Leaders: M. Eugene Tardy, M.D., and Trent W. Smith, M.D.
- 12 Noon Luncheon
- 1:30 PM **"Immune Disease-Cellular and Humoral Factors"**—Clark West, M.D., Professor of Pediatrics, University of Cincinnati.
- 2:30 PM Topic not available at this time—Hugh Biller, M.D., Professor and Chairman of the Department of Otolaryngology at Mt. Sinai Hospital, New York.

TUESDAY, MAY 11

This program, sponsored by the OSMA Section on Internal Medicine and the Ohio Society of Internal Medicine, will have in-depth discussions on Ileal Bypass Surgery and Peptic Ulcers.

"How to Manage the Medical Complications of Ileal Bypass Surgery"

Moderator: Donald E. Walker, M.D., Cincinnati, President-Elect, Ohio Society of Internal Medicine.

(continued on page 184)

Annual Meeting Update *(continued)*

9-10:30 AM Discussants: Richard C. Bozian, M.D., Professor of Medicine, University of Cincinnati; Yoichi Oikawa, M.D., Clinical Professor of Medicine, University of Cincinnati; and Carl I. Wyler, M.D., Assistant Clinical Professor of Medicine, University of Cincinnati.

"What's New in Peptic Ulcer"

Moderator: Jerome R. Berman, M.D., Professor of Medicine, University of Cincinnati.

10:30-11:30 AM Discussants: John Banwell, M.D., Professor of Medicine, Director of Gastroenterology, University of Kentucky, Lexington; Alastair M. Connell, M.D., Associate Dean, Mark Brown Professor of Medicine and Director of the Division of Digestive Diseases at the University of Cincinnati Medical Center; and Thomas A. Saladin, M.D., Associate Professor of Medicine, University of Cincinnati.

TUESDAY, MAY 11

The OSMA Section on Rheumatology and the Ohio Rheumatism Society will present the following program. The President is Robert P. Sheon, M.D., Toledo, and the Program Chairman is Robert I. Finkel, M.D., Toledo.

12 Noon Luncheon.

1:35 PM "Local and Systemic Factors in Infectious Arthritis"—Frank R. Schmid, M.D., Professor of Medicine and Chief of the Arthritis-Connective Disease Section, Northwestern University Medical Center, Chicago, Illinois.

2:30 PM "Drug Therapy of Rheumatic Disorders: 1976"—Marvin H. Thomas, M.D., Assistant Clinical Professor of Medicine at Ohio State University Hospitals, Columbus.

3:15 PM Break

3:30 PM "Early Roentgenographic Changes of the Hand and Wrist in Rheumatoid Arthritis"—Aaron S. Weinstein, M.D., Associate Professor of Radiology and Medicine, Cincinnati College of Medicine.

4:15 PM "A Bicentennial Look at American Rheumatology"—Allan B. Kirsner, M.D., Rheumatologist, The Toledo Clinic, Associate Clinical Professor of Medicine, Medical College of Ohio at Toledo.

TUESDAY, MAY 11

The OSMA Section on Physical Medicine and Rehabilitation and the Ohio Society of Physical Medicine and Rehabilitation will sponsor a luncheon beginning at 11:30 AM, in connection with the Annual Meeting.

At 1:30 PM, they will have Lawrence W. Friedmann, M.D., Chairman, Department of Rehabilitative Medicine, Nassau County Medical Center; Associate Professor of Clinical Rehabilitative Medicine, New York University; Chairman, New York State Education Department, Board of Massage; and Education Committee, American Academy of Physical Medicine and Rehabilitation, East Meadow, New York; speak on "Current Trends in Limb Prosthetics for Congenital and Acquired Absence."

The Presiding Officer is John Burkhart, M.D., Assistant Professor of Physical Medicine and Rehabilitation and Program Chairman of the Ohio Society of Physical Medicine and Rehabilitation.

TUESDAY, MAY 11

The OSMA Section on Anesthesiology and the Ohio Society of Anesthesiologists will present the following program on "Anesthesia." Thomas P. Beach, M.D., Assistant Professor, Department of Anesthesiology, Ohio State University, Columbus, will preside.

2-3 PM "Anesthesia for Neurosurgery"—John T. Martin, M.D., Professor of Anesthesiology, Medical College of Ohio at Toledo.

3-4 PM "An Overview of Obstetrical Anesthesia"—Thomas H. Joyce, III, M.D., Associate Professor of Anesthesia and Obstetrics and Gynecology and Director of the Division of Obstetrical Anesthesia, University of Cincinnati.

4-5 PM "Anesthesia for the Pediatric Patient"—Donald S. Nelson, M.D., Chief of Anesthesia Department, Akron Children's Hospital.

TUESDAY, MAY 11

The Section on General Practice and the Ohio Academy of Family Physicians will sponsor "Office Orthopedics for the Family Physician." The program features two outstanding speakers and will be moderated by Kenneth A. Frederick, M.D., Department of Family Medicine, University of Cincinnati Medical Center.

2-2:30 PM "Common Foot Problems: Diagnosis and Treatment"—Nicholas Giannestras, M.D., Department of Orthopedics, University of Cincinnati Medical Center.

2:30-2:45 PM Question and Answer Period.

2:45-3:15 PM "Tendinitis, Bursitis and Tennis Elbow: Which is Which and What to Do"—Edward Miller, M.D., Department of Orthopedics, University of Cincinnati Medical Center.

3:15-3:30 PM Question and Answer Period.

3:30-4 PM Business Meeting.

WEDNESDAY, MAY 12

The Ohio Ophthalmological Society and the OSMA Section on Ophthalmology will combine to present a postgraduate-type program for the 1976 Annual Meeting. The Course Director is Abbot G. Spaulding, M.D., Cincinnati, Program Chairman, Section on Ophthalmology. The following is their schedule:

8-9:30 AM Board of Governors, Ohio Ophthalmological Society.

9:30-9:45 AM "Diagnosis and Etiology of Cataract in Childhood"—Ronald L. Price, M.D., Staff Physician, Department of Ophthalmology and Pediatrics, Cleveland Clinic Foundation.

9:45-10 AM "Non-Surgical Management of Congenital Cataracts"—Rees W. Sheppard, M.D., Chief of Pediatrics, Ophthalmology Department, Children's Hospital and Assistant Clinical Professor of Oph-

thology, Cincinnati Medical Center.

10-10:15 AM **"Discision and Aspiration Technique of Congenital Cataract Surgery"**—Gary L. Rogers, M.D., Clinical Instructor, Department of Ophthalmology, Ohio State University and Associate Staff, Children's Hospital, Columbus.

10:15-10:45 AM **"Phacoemulsification of Infantile Cataracts"**—David A. Hiles, M.D., Clinical Associate Professor of Ophthalmology, University of Pittsburgh School of Medicine; Chief of Ophthalmology, Children's Hospital of Pittsburgh, Pennsylvania.

10:45-11 AM Coffee Break.

11-11:15 AM **"Congenital Cataract Surgery 'Other' Techniques"**—Ronald L. Price, M.D., Cleveland.

11:15-11:45 AM **"Visual Rehabilitation Methods Following Infantile Cataract Extraction"**—David A. Hiles, M.D., Pittsburgh, Pennsylvania.

11:45-12 Noon **"Long Term Prognosis and Results"**—Rees W. Sheppard, M.D., Cincinnati.

12-12:15 PM Panel Participation: Moderator: Richard Keates, M.D., Professor of Ophthalmology, Ohio State University, Columbus.

12:15-12:30 PM Business Meeting.

12:30-1 PM Cocktails.

1-3 PM Luncheon and Business Meeting.

WEDNESDAY, MAY 12

Two out-of-state guest speakers will participate in the program, **"Food for Thought,"** sponsored by the OSMA Section on Allergy and the Ohio Society of Allergy and Immunology. Richard Hong, M.D., is presently Professor of Pediatrics and Chief of Immunology at the University of Wisconsin Health Sciences Center, Madison, Wisconsin. Lloyd V. Crawford, M.D., is Clinical Professor of Pediatrics and Chief of the Allergy Section of the University of Tennessee Center for the Health Sciences, Memphis, Tennessee. The Course Director is Joseph E. Ghory, M.D., Director of Pediatric Allergy, University of Cincinnati. The entire program is as follows:

1:30 PM **"Nutritionally Speaking: Food Additives and Substractives"**—Richard C. Bozian, M.D., Professor of Medicine, University of Cincinnati.

2 PM **"Immunologically Speaking: The Leaky Gut Syndrome"**—Richard Hong, M.D., Professor of Pediatrics, Chief of Immunology at the University of Wisconsin Health Sciences Center, Madison, Wisconsin.

2:30 PM **"Allergically Speaking: Fact or Fancy?"**—Lloyd V. Crawford, M.D., Clinical Professor of Pediatrics-in-Chief-Allergy Section, University of Tennessee Center for the Health Sciences, Memphis, Tennessee.

3 PM Break

3:15 PM **"Pathologically Speaking: The Sloppy Stool Syndrome"**—William K. Schubert, M.D., Chief of Staff and Director of the Division of Gastroenterology of the Children's Hospital Medical Center, Cincinnati.

3:45 PM **"Practically Speaking: Making it Easy to Digest"**—Joseph E. Ghory, M.D., Cincinnati. Panel discussion with all speakers.

WEDNESDAY, MAY 12

The program sponsored by the OSMA Section on Colon and Rectal Surgery will be an afternoon of time well spent. Roscoe Earl Miller, M.D. of Indianapolis, Indiana, will be the out-of-state guest speaker. The Course Director is A. Gerson Carmel, M.D., Fairfield, Program Chairman, Section on Colon and Rectal Surgery. 11:45 AM Business session and luncheon.

1:30 PM **"Cryosurgical Hemorrhoidectomy"**—Walter J. Tims, M.D., Youngstown, proctology training at New York Polyclinic Medical School.

1:45 PM Discussion opened by Jack Selzer, M.D., Cincinnati.

1:45 PM **"The Barium Enema: Its Use and Abuse"**—Roscoe E. Miller, M.D., Professor and Chief of Gastrointestinal Radiology, Indiana University, Indianapolis, Indiana.

Barium Enema Panel: Moderator: Burchard E. Winne, M.D., Toledo; Roscoe E. Miller, M.D., Indianapolis, Indiana; Victor Scharf, M.D., Cleveland.

2:30 PM **"Procidencia of the Rectum"**—Frank L. Weakley, M.D., Cleveland Clinic, General Surgery Staff in Colon and Rectal Surgery. Discussion opened by Arthur Wells, M.D., Cincinnati.

3:15 PM Break

3:45 PM Colonoscopy Panel: Ralph Samson, M.D., Columbus; Armin V. Banez, M.D., Youngstown; and Henry W. Eisenberg, M.D., Cleveland. Question and Answer Period Panel: Jack Selzer, M.D., Cincinnati; Frank L. Weakley, M.D., Cleveland; and Victor Scharf, M.D., Cleveland.

WEDNESDAY, MAY 12

"The Ocular Fundus and Systemic Disease" program is sponsored by the Ohio Society for the Prevention of Blindness, Inc. The program will be presented from 1:30 PM to 3:30 PM. The purpose of the program is to educate non-ophthalmological physicians to methods of diagnosis and treatment of serious eye diseases in order to prevent needless vision damage. The program consists of a symposium on hypertensive, arteriosclerotic, and diabetic retinopathy, sickle cell disease, blood dyscrasias, and inflammatory diseases of the retina.

The moderator is Frederick Davidorf, M.D., Director of Retina Unit, Department of Ophthalmology, Ohio State University, Columbus. The advisor is William H. Havener, M.D., Chairman, Department of Ophthalmology, Ohio State University, Columbus.

Participants are Frank J. Weinstock, M.D., Chairman, Medical Advisory Committee, Ohio Society for the Prevention of Blindness, Columbus; Jack Dingle, M.D., Resident, Ophthalmology Department, Ohio State University, Columbus; and Kenneth Rowe, Jr., M.D., Ophthalmologist, Holmes Hospital, Cincinnati.

Art Show Planned

FOR 1976 OSMA ANNUAL MEETING

Space will be provided at the 1976 Annual Meeting of the Ohio State Medical Association, May 10, 11 and 12, at the Cincinnati Convention Center for a Physician's Art Show. The Art Show will be under the direction of Harry H. Fox, M.D., local Cincinnati physician as well as, Chairman of the Art and Culture Committee of the Medi-Club of the Academy of Medicine of Cincinnati. Dr. Fox directed the outstanding 1972 Art Show held in Cincinnati.

Members of the OSMA, their wives (or husbands), who are interested in exhibiting art pieces (they personally have created) or who require information regarding the exhibit, should fill out the application included below without delay.

It will be the responsibility of each exhibitor to see that his work gets to the Cincinnati Exposition Center. Final arrangements will be taken care of by a committee.

The OSMA will provide suitable display facilities, but each physician and/or wife is responsible for transportation costs and any other such expense involved in entering his or her exhibit. Art show security will be on duty.

Exhibitors will be limited to two art pieces per category.

An Art Award Committee will judge the exhibit competitively.

We solicit your exhibits to make the 1976 Art Show an outstanding success.

Application for Space in Art Show Exhibit

Mail to: Harry H. Fox, M.D., Chairman
1976 OSMA Art Show Committee
19 West Eighth
368 Doctors Building
Cincinnati, Ohio 45202

Name _____

Address _____

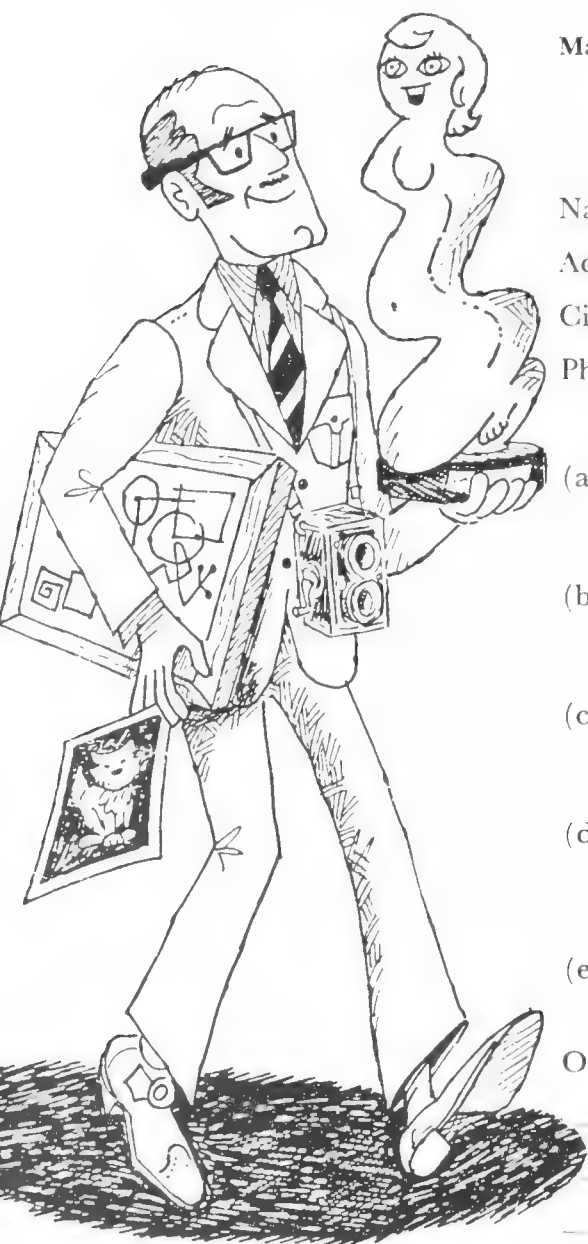
City _____ Zip Code _____

Phone No. _____

	Title	Dimensions	Value*
(a) Paintings (watercolor)	1. _____	_____	_____
	2. _____	_____	_____
(b) Paintings (oil or acrylics)	1. _____	_____	_____
	2. _____	_____	_____
(c) Sculpture	1. _____	_____	_____
	2. _____	_____	_____
(d) Photo-Arts (preferably mounted to hang)	1. _____	_____	_____
	2. _____	_____	_____
(e) Crafts (variable)	1. _____	_____	_____
	2. _____	_____	_____

Other information (which you believe will be helpful to the Art Show Committee) _____

(*Please include a fair market value for insurance)





Dr. Charles Dutton (1777-1842) Youngstown's First Doctor

John C. Melnick, M.D.

The following bicentennial article is reprinted from *The History of Medicine in Youngstown and Mahoning Valley, Ohio* by John C. Melnick, M.D. This particular chapter is devoted to Charles Dutton, M.D., Youngstown's first physician, who arrived in the area in 1801. Dr. Melnick believes that Dr. Dutton was the second physician in the Western Reserve Territory; Dr. Thompson of Hudson, Ohio, was the first.

The history of medicine began in Youngstown, Ohio, in 1801 with the arrival of Dr. Charles Dutton at the age of 24. It was 25 years after the Declaration of Independence, and eight years had elapsed since General George Washington was inaugurated as first President of the United States. The State of Ohio was not to be a state for another two years, and John Young, son of a doctor, had approximately four years previously surveyed the town and established Federal St. as the only street in his new township of 200-300 people.

During the early part of the nineteenth century, the pioneers suffered from diseases that are essentially non-existent in our community today. The average life expectancy was less than 30 years. Malaria was a common disease, as was typhoid fever, smallpox, pneumonia and diphtheria. A serious problem was a compound fracture since without antibiotics the mortality rate approached 50 percent.

The area still had bears, wolves, fox and wild turkeys when Dr. Dutton arrived. A number of Indians lived in the vicinity. Some lived quietly beside the white man, whereas some were still hostile.

Dr. Charles Dutton was born in Wallington, Connecticut in 1777. He studied medicine under Dr. Jared Potter, grandfather of Dr. Jared Potter Kirtland of Poland, Ohio, and afterwards of Cleveland, Ohio. He was just beginning his practice of medicine in Wallington when Turhand Kirtland, father of Dr. J.P. Kirtland, stopped for the night. Mr. Kirtland was wagonmaster leading a group of emigrants from Connecticut in three four-horse wagons for the Western Reserve Territory. Dr. Dutton is frequently referred to as having an "eccentric disposition." This, coupled with the excitement of new lands and riches, in addition to the pioneering spirit, is said to have prompted Dr. Dutton to suddenly spring upon a driver's seat of one of the wagons, crack his whip and start off the team as he sang the chorus of "Jefferson and Liberty," in an elevated voice, a political song of the day:

"Rejoice, Columbia's sons, rejoice!

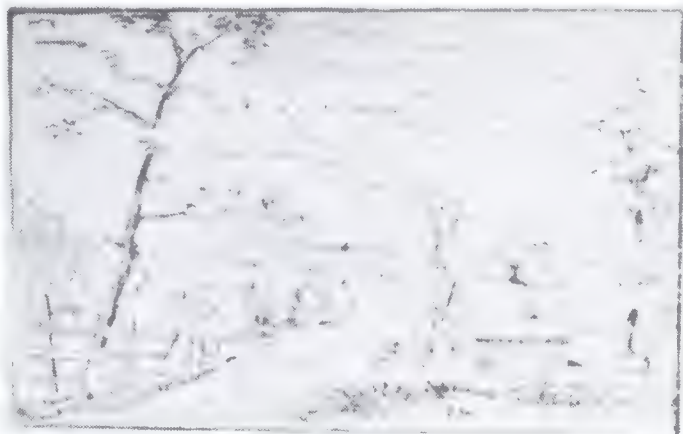
To tyrants never bend your knees,
But join with heart and soul and voice,
For Jefferson and Liberty."

His aged and widowed mother with tears in her eyes, relatives and friends, gathered around to bid him farewell. Dr. Dutton, without noticing them, gathered up the reins and drove off the team. This episode of his departure is attributed to Dr. J.P. Kirtland. The journey west was uneventful during the several weeks of travel.

The first male child born in Youngstown was Isaac Swager, son of Mr. and Mrs. John Swager. The first female child was the daughter of Robert and Hannah Stevens. Both births are thought to have occurred prior to 1800, and therefore the deliveries were not by Dr. Dutton. Delivery fees in the early 1800's were \$6.00 for a boy and \$5.00 for a girl. The first funeral, that of Samuel McFarland, a vocal music teacher from Worcester, Massachusetts, was in September 1799. The entire town turned out, including John Young.

Over a period of time, Dr. Dutton acquired a substantial amount of land. On July 14, 1802, he purchased from John Young two acres of land on the south side of West Federal Street. This original purchase was 330 feet (20 rods) wide, facing West Federal Street, and cost \$200.00. He later bought two additional adjoining parcels of land from George Tod to the west of his first lot, which were 2 and 2½ acres respectively. Mr. Tod had bought the land from John Young in 1801 for \$10.00 per acre. Dr. Dutton's purchase of land from Young was the fourth sale by him, and the land purchased from Mr. Tod were sales number 5 and 6 by Young in 1801. The land laid between Spring Common and Chestnut St. and was adjacent to lot #35 of the original Youngstown Township Plot consisting of 100 lots. Dutton erected a log cabin, and later a frame house, and lived there his entire life.

(continued on page 188)



Youngstown in 1830: Dr. Charles Dutton lived here at the time this sketch was made. This is the earliest known picture of Youngstown. It is reproduced here through the courtesy of The Arms Museum, Youngstown.

Dr. Charles Dutton (continued)

In 1804, with Caleb Plumb, he purchased land on the east bank of the Mahoning River from John Young, and an acre from James Hillman for one dollar on the west bank of the river. They erected a log building and a crude dam for a saw mill and a grist mill. In 1806, Dr. Dutton bought out Mr. Plumb and greatly enlarged the mill. The mill was located east of Spring Common in the area of the now Marshall Street Bridge. A portion of the dam still exists and may be seen today. In the mill venture, Caleb Plumb was the millwright and part owner along with Dr. Dutton and James Hillman. The mill burned down in 1855. Title then passed to Homer and Jesse Baldwin who built a new mill which became the "House of Many Gables." This mill also was destroyed by fire. It was replaced by a large building which was used for manufacture of war materials by the Buffalo Pressed Steel Co.

Dr. Dutton was the only physician for ten years when Dr. Henry Manning arrived in 1811 (an article on Dr. Manning will appear at a later date). In spite of being the only doctor in the township, Dr. Dutton was not extremely busy with the practice of medicine. He had the opportunity to become involved politically, socially, and to pursue hobbies as well as business ventures. He was appointed Youngstown's second postmaster and held this position from July 1803 to March 9, 1818. A copy of the quarterly account from October 1 to December 31, 1817, was preserved among his papers which showed the amount of business in the office at that time. The amount collected on letters was \$35; on newspapers, \$3.79; total \$38.79; paid general post-office, \$25.60; total \$13.19. In later years Dr. Dutton was elected a Township Trustee and held other township offices during his time.

Dr. J.P. Kirtland in 1811 spoke of Dr. Dutton as "the leading physician and surgeon of the vicinity and sustaining a favorable reputation in that capacity of energy and good judgement." Another physician who knew him well said, "Dr. Dutton was regarded by the

medical men of the Reserve as an able man, a very good surgeon for those days and a successful physician; was thought to be somewhat heroic in practice. He was a shrewd man, possessing discriminating judgement, somewhat eccentric, sometimes a little rough, very social, having a large share of those kind feelings which go into the make-up of a good physician and I may add enter into the composition of a good man."

Dr. Dutton made house calls on horse back. His saddle bags contained his lancets, emetics and doses of calomel. Physicians did the best they could with their limited tools and drugs. There were no bridges across the Mahoning River. When going south, people crossed at Power's Fork, near the present Center Street Bridge. According to Dr. Dutton, if the top of a certain rock was visible, the river was safe to cross since often rains would cause the river to rise considerably. In addition to his practice of medicine, Dr. Dutton pursued farming and stockraising, with particular interest in raising mules.

During the War of 1812, the countryside was mobilized and rendezvoused in Youngstown. A hundred men enlisted under the command of Colonel William Rayen (Rayen School, Rayen Avenue). Colonel James Hillman (Hillman Junior High School, Hillman Street) was appointed by General Harrison, the wagon-master general. John E. Woodbridge was paymaster. The only men left in Youngstown were: Bruce, Hague, Thorne, Moses Crawford, Henry Wick, Hugh Bryson and Dr. Dutton.

Dr. Dutton was married twice. His first wife was Cynthia, who bore him a daughter, Jane, who married Dr. Lemuel Wick, son of Henry Wick. Cynthia died on April 26, 1816 at the age of 31. His second wife was Cordelia Poole, whom he married on April 7, 1822, and she survived Dr. Dutton by several years. No children were recorded from this marriage.

In his latter years, Dr. Dutton did not practice a great deal of medicine, but looked over his investments. He did act as consultant to the younger doctors of the time. Dr. Dutton died in March, 1842, at the age of 65, and was buried in the original cemetery laid out by John Young, but was later moved to Oak Hill Cemetery. He is located in lot #83 with other members of his family. In his memory, Dutton Alley appeared about 1860 as the name given to the alley between the rear of the Home Savings and Loan building and the Youngstown *Vindicator*.



Baldwin's Mill, which was built on the site of Dr. Dutton's "Red Mill" which had burned down. Photo circa 1870, courtesy of The Arms Museum, Youngstown.

John C. Melnick, M.D., of Youngstown, received his medical degree from Case-Western Reserve University. He is Radiologist and Director, Nuclear Medicine Department, at the Youngstown Hospital Association, South Unit. A member of OSMA, Dr. Melnick has served as Delegate from Mahoning County for six years. Professional memberships of Dr. Melnick include the American College of Radiology, American College of Nuclear Medicine, American Roentgen Ray Society, Radiological Society of North America, and Rocky Mountain Radiological Society. Dr. Melnick is also on the Board of Directors of the Mahoning Valley Historical Society, the Chairman of the Historical Committee of the Mahoning County Medical Society, and a member of the Western Reserve Historical Society.

- 3. The DLP checks with the appropriate individual or committee of the local County Medical Society to determine whether, in the society's judgment, there is sufficient reason to believe the physician in question is ill. This does not require any initiative on the part of the County Medical Society, but simply confirmation from it that other physicians share the concern that this particular colleague might be ill.
- 4. The DLP reports to the Chairman of the Physician Effectiveness Program that sufficient cause exists to justify contacting the physician thought to be ill.
- 5. The chairman writes to the physician, explaining the nature of OSMA's program, the general circumstances leading to his letter (preserving anonymity for all individuals involved), and urging the physician to seek appropriate evaluation and treatment. This letter also indicates that the DLP will contact the physician personally to make appropriate arrangements.
- 6. The DLP contacts the disabled physician and offers to help if any problem exists.
- 7. If the physician in question denies any illness or

refuses assistance, the DLP reports this to the chairman. Similarly, if the physician in question agrees to see the attending physician, but does not do so, a report of this is made.

8. After a suitable interval, the chairman again writes to the physician in question, urging him to seek assistance. The letter points out the responsibility to report the situation to the Ohio State Medical Board if no corrective action is taken voluntarily.

9. The DLP follows with telephone contact, stressing the same points as the chairman.

10. If the physician in question still denies illness or declines assistance, the DLP again reports to the chairman. After discussion and agreement among the members of the Committee on Mental Health (with the name of the disabled physician omitted), the chairman communicates the facts of the case to the Ohio State Medical Board, preserving the anonymity of the original concerned peer and of specific individuals contacted by the DLP in the local County Medical Society. OSMA's involvement ends at this point.



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The Claims-Made Concept

Layton C. Severson, Claims Manager, Joint Underwriting Association

Claims-made insurance is a type of professional liability protection which covers current legal obligations resulting from professional acts of the insured doctor or hospital. It provides coverage to the doctor or hospital for claims reported during the 12-month term of the policy. It is a pay-as-you-go policy: claims reported this year are covered by this year's policy and the policy is priced accordingly. Next year's claims will be covered by next year's policy.

The claims-made policy provides the insured doctor or hospital the same degree of financial protection from the consequences of medical negligence allegations as does the "occurrence" policy, but it covers malpractice claims one year at a time. The premium pays for the risk of a claim being reported while the policy is in force. The basic difference is that the occurrence policy premium is a pay-in-advance premium; it pays for the risk of the claim being reported some time in the future from professional act, such as surgery, rendered while the policy was in force.

Any claim reported is covered by the claims-made policy then in force, regardless of when the alleged incident occurred as long as it occurred during the time when the doctor or hospital was continually insured by a claims-made contract with no interruption in coverage. When the coverage is discontinued, a tail (extended reporting endorsement) is purchased.

Professional liability insurance is unique among insurance coverages. "Malpractice" insurance is especially unique among all professional liability coverages. The company's final cost of providing this product is not known until five or more years after the coverage has been priced and sold. Insurance rate adjustments do not recover past losses; they are based on claims experience. The pattern of claims experience is used to determine the future cost of the policy now being sold.

The pricing problem with malpractice insurance is the "long tail," an industry term. It means that it will be some time in the distant future before all of the claims arising out of this year's professional acts will be reported and settled. An occurrence policy covers an insured doctor for malpractice incidents alleged to have occurred during the 12 months the policy was in force.

Few injuries become known the first year. Medical "injuries" can take years to develop into a pain or other problem the patient notices and for which he seeks treatment. The patient may conclude that the pain or other problem must be due to an operation he or she had years before. The patient may be right or wrong, but even if the claim is without merit, it costs dearly to defend it.

The longer a claim goes unsettled, the higher the cost of handling the claim, the more inflation affects the size of any settlement or jury award, and the more time

necessary for legal defenses to be awakened because of erosions in the law.

We must allocate funds today to cover present incidents payable in the future and establish rates for the present to pay claims reported in the future. For every substantive claim reported, we set up a "reserve." The reserve is our best estimate, given current jury award patterns and the nature of the law, of the probable amount of any payment and the amount of expense that will be involved in the handling of the claim.

Another reserve is the "incurred but not reported" reserve (commonly referred to as the IBNR). This is a reserve for all those harms that experience tells us have occurred this year, but we do not know where or when. They have not been reported yet. They will be reported during the next five years or more as patients experience problems, decide their doctors did not follow the proper standards of care, and file claims. The insurance industry's present rate-making techniques must take these claims-to-be into account. The objective is to have enough money in reserves at the end of any given year to pay all of the claims arising from the malpractice incidents which occurred during that year, but which have not been paid or reported.

Reserves must exist to pay every just claim even if a company stopped writing any new business. The impossibility of proving beyond a shadow of a doubt that the IBNR reserve is neither too high nor too low compounds the difficulty of explaining and obtaining needed rate increases. Most companies are uncomfortable because they will not know for certain that their IBNR reserve is correct until at least five years after the year in which the policies were sold. With the rapidly changing claims climate, including the effects of economic and "social" inflation of injuries and jury awards, we face a very uncertain future under the occurrence type of policy. Actuaries tell us that they can no longer properly price the risk on an occurrence policy in areas such as medical negligence.

This is as if a car manufacturer tried to set a fair price today for a car he would not manufacture and deliver until 1980. He does not know what labor and raw materials will cost in 1980 or the kind of safety and pollution control requirements government will require be built into every 1980 car.

By guaranteeing to sell the doctor or hospital coverage for claims not yet reported when the doctor retires or is otherwise no longer insured by Joint Underwriting Association, our claims-made policy provides the doctor with the option to purchase the same degree of financial protection as the occurrence policy. We are required by law to make this "tail coverage" available to each and every insured.

Perhaps an example of how the claims-made policy works will serve to clarify the coverage.

For example, until 1975 Doctor X has been insured under an occurrence contract. Thus, claims reported any time, resulting from professional acts rendered up to 1975, are covered under those occurrence policies.

On May 1, 1975, the doctor buys a claims-made policy. Any claim reported from May 1, 1975, to April 30, 1976, that resulted from a professional act rendered during that period, would be covered. It is not necessary that the claim be settled before April 30, 1976, only that the claim (or an incident the doctor has reason to believe may lead to a claim) be reported by that date.

As time goes on, Doctor X continues to carry claims-made coverage. The retroactive date remains May 1, 1975. Any claim reported resulting from a professional act on or after May 1, 1975, will be covered by the claims-made policy in force on the date the claim is made, provided the doctor has continually carried a claims-made coverage form.

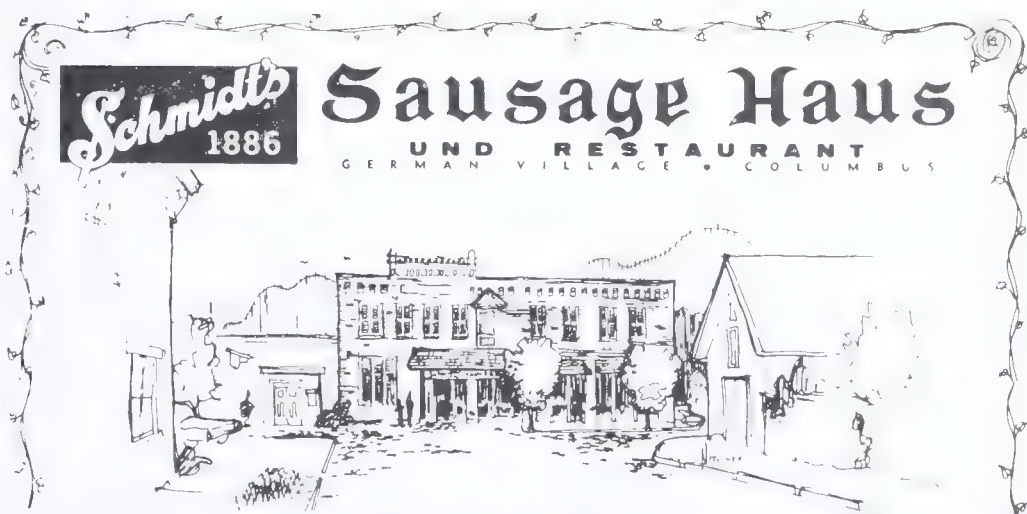
The doctor is not "locked to" the JUA or any company writing claims-made coverage. Any time coverage with us is discontinued by the doctor or us for any reason, the doctor is guaranteed the right to purchase reporting endorsements that will cover any claim that may be reported in the future, arising from an incident that took place while the doctor was insured under this claims-made coverage. For this coverage (tail), the doctor will pay a premium each year for three years at a rate calculated at that time to reflect current claims costs. A one-time payment for the reporting endorsement (tail) is also available.

As you can see, by using this system one of the biggest problems in rating has been eliminated. I refer, of course, to the incurred but not reported reserves. Rates for claims-made policies will be based on claims actually reported to date. We will project only months ahead, not years.

The claims-made policy should better enable the company to explain and justify to the doctors, hospitals, insurance regulators, and other interested parties any rate changes that it feels may become necessary.

In closing, it should be noted that claims-made policies will not solve fundamental malpractice problems. It is to our advantage and to the advantage of other insurers to institute programs that will remedy the rising claims frequency and costs of claims. Otherwise, the problem may very likely continue to grow at the pace it has in the last several years. There are many reasons for the problems and escalation of medical negligence claims; and, I am certain, with a little reflection, any individual can come up with a rather substantial list.

It is hoped that the preceding discussion will help the physician and health care provider to understand the claims-made concept. The JUA receives calls every day inquiring as to what the tail will cost in three years or five years. As you can see, above, it is impossible for us to know today what the rates will be in years yet to come. One thing appears certain at this point: the doctors are just the tip of the iceberg. In the not too distant future, we will probably see the same problems relating to all other areas of professional nature and to consumer oriented-services such as products liability.



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Medivest, Inc. is an Ohio investment advisory firm. The firm specializes in providing investment advisory information services designed to lower its clients' tax liabilities through investments in well-conceived and economically sound tax shelter programs, as well as information concerning venture projects that meet its stringent investment standards.

The Medivest, Inc. system, as a matter of policy, will not consider any venture project that cannot provide reasonably justifiable projections that will not show a better than 300-percent return in five years. Medivest, Inc. recognizes that the venture capital situation must offer, as an incentive, an opportunity to substantially increase the available return as compared to the type of relatively low-risk investment opportunity currently attracting the majority of investment capital.

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POSITION WANTED: Seeking a position as Radiology Administrator in Ohio. ARRT certified with M.S. in Radiology Administration. Please send requests for resume to Box 760, c/o Ohio State Medical Journal.

Physician for **OHIO STATE INSTITUTE FOR MENTAL RETARDATION**—opening immediately available for qualified physician on full or selected time basis at center for mental retardation. Either contract of supplemental pay scales. Salary negotiable. Family practice, pediatrics, internal medicine, neurology backgrounds most acceptable. Contact J. F. Quilty, M.D., Medical Director, Columbus State Institute, 1601 W. Broad Street, Columbus, Ohio 43223. Telephone 614/272-0509.

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WANTED: Internists—General or with special interests in pulmonary or cardiology to join busy practice in Ohio. Offering \$40,000, malpractice insurance, free overhead expenses, partnership in two years. All correspondence should be addressed to Florencio E. Yuzon, M.D., 480 Park Ave., Amherst, Ohio 44001.

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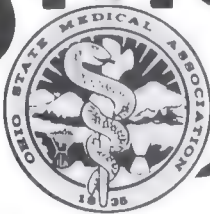
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APRIL, 1976
Volume 72, Number 4

THE OHIO STATE Medical Journal



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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyper-excited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MAXIMUM ALLOWABLE COST REGULATIONS

The Council first considered a resolution on "Maximum Allowable Cost Regulations" submitted by the Committee for presentation at the 1976 Annual Meeting of the OSMA. The Council amended the resolution and agreed to sponsor it.

POLICY ON PL 93-641

After extensive discussion of PL 93-641 and its implications for medicine, the Council adopted the following policy and directed that it be forwarded immediately to all of Ohio's county medical societies:

OFFICIAL POLICY OF THE OSMA REGARDING PUBLIC LAW 93-641, THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974.

"The Association herewith reiterates its strong and definite position that this law is dangerous to the provision of quality medical care and that it violates the Constitutional rights of both the consumers and the providers of health care.

"The Association took the position, when this legislation was pending in Congress, that it was bad legislation that should not be passed. This position was presented forthrightly to Ohio's Congressmen and U.S. Senators.

"When Congress enacted the legislation, the OSMA urged President Ford to veto it on the basis that it would be detrimental to the preservation and expansion of quality medical care in the U.S.

"The Association strongly supports the declared intention of the AMA that legal action will be taken when such action becomes feasible. Further, this Association endorses and urges all Ohio physicians to support the position of the AMA, namely:

'Until such time as legal action is feasible, the Association will follow a course of activity designed to protect the interests of the public and assist the Federation in carrying out its responsibilities. Such assistance will include: review and comment on published or promulgated regulations; participation in conferences and meetings, sponsored by others, to express AMA viewpoints; expansion of AMA Speakers' Bureau subject matter to include addressing this law and its implications; convening of conferences and meetings to publicize AMA's concerns and provide a forum for discussion within the profession; provision of information and assistance in response to specific requests from the Federation; at the request of medical societies, cooperate, where desirable, with Health Systems Agencies with respect to informational needs; and the assignment of substantial space in AMA publications to the coverage of developments in the law.'

"The OSMA calls on Congress to repeal this undesirable act.

"Further, the OSMA urges all its component medical societies and all its physician members to inform themselves, fully and deeply, as to the specific contents of Public Law 93-641, to insist that physicians have a meaningful and effective role in health planning developments and in Health Systems Agencies within their Health Service Areas, and to strive to protect the medical rights and medical best interests of their patients.

"The Council of the OSMA emphasizes that the re-

sources of the Association are available to component medical societies and to physician members in carrying out the precepts of this position regarding Public Law 93-641."

TASK FORCE ON PROFESSIONAL LIABILITY

The Council **approved** the following recommendations of the Task Force with regard to anticipated "ISO" (Insurance Service Organization) malpractice premium rate filings.

1. That the OSMA develop a statement opposing any malpractice rate increase filings.

2. That the OSMA should request formal hearings by the Ohio Department of Insurance in the event ISO filings are made at greatly increased premium rates.

3. That the OSMA develop a statement to inform OSMA membership of possible ISO rate increases and current Task Force activities.

The Council considered proposals made by representatives of the Ohio State Neurosurgical Society and amended and adopted the following Task Force recommendations:

1. The OSMA should continue to work with the State Medical Board to provide quality health care delivery in Ohio and to encourage the Board to strengthen its activities through utilization of the language gained by the passage of H.B. 682. The Task Force submitted the comment that historically it is the "more skillful" doctors not the "less skillful" doctors who have had a higher incidence of malpractice suits.

2. The OSMA should endorse and cooperate with the high risk specialists in a solicitation of funds for a court docket survey and this funding should be used in part to investigate and develop background information concerning possible countersuit activity in Ohio in appropriate medical malpractice cases. Data development is already being undertaken by the OSMA through a nationally respected actuarial firm and a portion of this solicitation should go toward off-setting the costs of these actuarial studies. The funding should be done through a separate solicitation coordinated by the OSMA Task Force on Professional Liability, and not through OSMA dues dollars.

3. The Public Relations Department of the OSMA is already working very hard in the area of malpractice news releases and has been working with OSMA spokesmen for some time developing news media coverage in this area, and should continue to do so.

4. An area around Columbus could be used for a court docket survey described in Item #2 but some other cities should definitely be included so that the data may be statistically viable.

The Council adopted a recommendation of the Task Force that OSMA staff continue the development of background data concerning the establishment of a captive professional liability insurance company and that a report be available for the 1976 OSMA House of Delegates meeting.

Legislative Update

"PATIENT'S BILL OF RIGHTS" HAS TWO HEARINGS

The Senate Judiciary Subcommittee heard testimony on S.B. 363, Headley (D-Barberton), the "Patient's Bill of Rights," in an effort to attempt to get the bill back to full Committee in some form that can receive favorable passage. Senator Timothy McCormack (D-Euclid), Chairman of the Subcommittee, has asked the Ohio Hospital Association and the OSMA to produce amendments to the bill and such amendments have been drafted. Among other proposals, the OSMA has suggested the deletion of some of the proposed "rights" stating that they might leave the physician open to additional civil liability and has suggested that the Subcommittee consider instructing the Ohio Public Health Council or some other governmental entity to develop a "Patient's Bill of Rights" instead of legislating it as in S.B. 363.

PHYSICIAN'S ASSISTANT AMENDMENT COMPROMISE POSTPONED

The Ohio Nurses Association, testifying that they represented Ohio's 65,000 nurses even though they only have 12,000 members, refused to compromise on an important part of Sub. H.B. 663, Hale (D-Columbus), to register physician's assistants in Ohio.

Representatives of the OSMA, along with Subcommittee Chairman Senator Neal F. Zimmers, Jr. (D-Dayton), agreed with the Ohio Nurses Association that a physician's assistant should **not** originate any medical orders. However, when the OSMA, in a proposed compromise amendment, pointed out that the physician's assistant should be allowed to transmit an order from his or her employing physician to an R.N. or an L.P.N., the ONA would not agree, stating that the order might be "garbled." Senator Zimmers, who felt that the proposed amendment was a satisfactory compromise, has not yet indicated whether a further hearing will be held on this bill. The OSMA will continue to attempt to try to establish high standards of educational requirements for physician's assistants and will attempt again to work with the Ohio Nurses Association on the proposed changes.

MENTAL HEALTH BILL GOES TO SUBCOMMITTEE

The Senate Judiciary Committee this week heard testimony on H.B. 1215, Jaskulski (D-Garfield Heights), to allow the Director of the Department of Mental Health and Mental Retardation to have better control over employees within Ohio's mental institutions and to allow the sale of some state lands to provide capital funds for the Department. Robert Clinger, Secretary of the OSMA Committee on Mental Health, testified in support of the bill after which time the bill was placed in a subcommittee consisting of Senator Anthony J. Celebrezze, Jr. (D-Cleveland), Chairman, Senator Thomas A. Van Meter (R-Ashland) and Senator Neal F. Zimmers, Jr. (D-Dayton). The OSMA will try to assist the Subcommittee to get H.B. 1215 back to the Senate Judiciary Committee and then to the Senate floor in the very near future.

ANTI-SUBSTITUTION REPEAL BILL DRAFT DISCUSSED

Representatives of the OSMA met with the Administrative Assistant for Senator Robert Freeman (D-Canton) and representatives of various interested groups concerning a proposal by Senator Freeman to repeal Ohio's anti-substitution laws and to establish a formulary program for State and Federally reimbursed medical programs. The Senator's draft proposal includes a provision allowing a pharmacist to substitute an "equivalent" drug unless the physician, in his own handwriting, indicates on the prescription blank that the prescription is to be "dispensed as written" or "D.A.W." Representatives of the OSMA indicated that the House of Delegates' meeting in May will review a suggested resolution from the OSMA Council objecting to any substitution. The representatives of the various interest groups agreed to meet again after the Senator's Aide has an opportunity to further review responses made at this week's meeting.

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COVER: Pictured are members of the Ohio House and Senate who lunched with members of the OSMA Auxiliary during its "Day at the Legislature" program in March. Legislators pictured are (beginning in the noon position and moving clockwise): Sen. Neal F. Zimmers, Jr., Dayton, with D. Brent Mulgrew and David L. Rader of the OSMA Department of State Legislation; Mrs. Fran Krone, OSMA Auxiliary President; Sen. William H. Mussey, Batavia; Sen. M. Morris Jackson, Cleveland; and Sen. M. Ben Gaeth, Defiance.

How many side effects would you expect from a drug that's taken 140 million times a day?

Like any active, effective pharmacologic agent, aspirin may produce side effects in certain patients. But for a drug that's administered millions of times each day, billions of times a year, aspirin remains exceptionally well tolerated.

According to the American Medical Association Department of Drugs,¹ serious adverse reactions from usual analgesic doses of aspirin occur infrequently. In therapeutic doses, the most significant side effects are gastrointestinal in nature—and may include dyspepsia, nausea, vomiting and occult G.I. bleeding.¹⁻³ When single or even repeated analgesic doses are given, the incidence of dyspepsia is small.^{2,3} In fact, many patients who claim they cannot tolerate aspirin, accept it quite well when it is disguised or given on a blind basis.^{2,3}

Allergic reactions to aspirin (ranging from minor skin rash to urticaria to anaphylaxis) are also relatively uncommon—with the incidence estimated by some to be 0.2% or less, in the general population.^{4,5} Although such reactions may be seen more frequently in patients with respiratory allergy—particularly asthma—the incidence here is still only 2% to 4%.⁴...with sensitivity occurring primarily in late-onset, non-atopic asthmatics exhibiting concurrent nasal polyposis.⁶

So the next time the subject of aspirin side effects is raised, consider the benefit-to-risk ratio of aspirin as it actually exists...its undiminished efficacy over 75 years of clinical use...and its remarkably low cost to patients—about a penny per tablet.

And when you do decide on aspirin, specify the brand that's synonymous with quality and dependability—Bayer® aspirin.



References: 1. AMA Department of Drugs: AMA Drug Evaluations, 2nd Edition, Acton Massachusetts, Publishing Sciences Group, Inc. p. 264. 2. Beaver, W.T.: Am. J. Med. Sci. 250:577 (Nov.) 1965. 3. Beaver, W.T.: Modern Treatment 5:1094 (Nov.) 1968. 4. Weiss, H.J.: JAMA 229:1221 (Aug. 26) 1974. 5. Lampe, K.F., in Medical News: JAMA 229:1704 (Sept. 23) 1974. 6. Falliers, C.J.: J. Allergy Clin. Immunol: 52:141 (Sept.) 1973.

Aspirin from Bayer
purity...quality...stability

Glenbrook Laboratories, Division of Sterling Drug Inc., 90 Park Avenue, New York, New York 10016

Group Term Life Plan Dividend

Maurice F. Lieber, M.D., President of the OSMA, has announced a sizable dividend of 44 percent for those members who participate in the association's Group Term Life Plan.

This dividend, which covers the policy year ending August 31, 1975, was credited to the March 1st semi-annual premium. The dividend also applies to those members and their employees who are covered under the OSMA corporate plan.

Turner and Shepard, Inc., plan administrator, also announced that the premium for Group Term Life has been reduced 10 percent, effective March 1, 1976. The maximum benefit available under the plan was increased from \$75,000 to \$100,000.

OSMA New Members

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during February 1976. List shows name of physician, county, and city in which he is practicing or in which he is taking postgraduate work.

Allen (Lima)

Robert C. Rau
Julio Salinas

Champaign (Urbana)

Barry L. Paxton

Coshocton (Coshocton)

Linda J. Magness

Cuyahoga (Cleveland unless noted otherwise)

Robert T. Brodell,
Rochester, N.Y.
Lloyd S. Goldman
Florence K. Matthews
Adrian M. Schnall

Delaware (Delaware)

John W. McGrail

Erie (Sandusky)

Robert S. Sawicki

Geauga (Chardon)

Harry B. Pearce

Guernsey (Cambridge)

William S. Quigley
Delia M. Slaga
Harry B. Tompkins

Lake

Kurt A. Bertschinger,
Willoughby
Norma P. Villeno,
Painesville

Lucas (Toledo unless noted otherwise)

Mohamad B. Abaza
Harvey L. Handler
William L. Horvath
Mohamed H. Rasheed,
Maumee
James G. Ravin

Miami (Piqua unless noted otherwise)

Choon-Gill Hoang
Azher A. Quader,
Troy
Mahesh M. Shah

Montgomery (Dayton)

C. Alex Alexander
Sylvester H. Pratt
Cyrus Rahimi
Leroy Vickers

Richland (Mansfield)

Leodegario Nierras
Michael P. Krieger
Joseph E. Stolfi
Frederick J. Wiecher
Robert F. Wiley, Jr.

Sandusky (Fremont)

Abraham K. Joseph
P. I. Mathew

Stark (Massillon unless noted otherwise)

Ilhan H. Bumin
John C. Frich, Jr.
P. K. Natrajan, Canton

April Enrollment Month For Disability Income Plan

Turner and Shepard, Inc., administrator for the OSMA's group insurance, has designated the month of April for enrollment by members who wish to participate in the group Disability Income Protection Plan.

This plan has been improved to include a Rehabilitation Benefit at no additional cost. This is a provision allowing for a mutually agreed upon rehabilitation program in case of disablement.

During this enrollment, all members under age 56 years may apply; however, their applications are subject to approval by the insurance company. Noninsured members, under age 45 years, are eligible for a plan providing benefits of \$100 per week (lifetime) for an accident and two years for an illness, regardless of health.

An enrollment application and a brochure describing the plan have been mailed to members.

OSMA to Coordinate Voluntary Solicitation for Professional Liability Study

In cooperation with various high-risk specialty societies, the OSMA Task Force on Professional Liability in conjunction with the OSMA Council has recommended that OSMA undertake a major study of the professional liability situation in Ohio. This program is to be financed by voluntary contributions from the physicians of Ohio.

The study will include a court docket survey, investigation of a captive insurance company, the funding of actuarial costs, and research into the feasibility of countersuits. In addition, a membership survey may be warranted regarding individual experiences with professional liability.

A statewide public relations effort will be coordinated with the study in order to bring the professional liability situation into focus for the public.

All OSMA members will be solicited for a voluntary contribution of at least \$100 per individual. The Task Force will contact each OSMA member in the near future to solicit his support, as will many of the specialty societies.

Questions concerning this project should be directed to the OSMA Headquarters.

OSMA Candidates For President-Elect

Stephen P. Hogg, M.D.

Stephen P. Hogg, M.D., was nominated for the office of President-Elect of the OSMA by the Academy of Medicine of Cincinnati. Neal N. Earley, M.D., President of the Academy of Medicine of Cincinnati, wrote:

"The Council of the Academy of Medicine of Cincinnati has voted unanimously to nominate Stephen P. Hogg, M.D., Councilor First District, for the Presidency of the Ohio State Medical Association. Dr. Hogg's candidacy was placed before the Council mutually by Dr. John E. Albers and Dr. Stewart B. Dunsker.

"The Council of the Academy feels that Dr. Hogg is eminently qualified by virtue of his activities and accomplishments locally and statewide to hold the position of President of the Ohio State Medical Association. Dr. Hogg has been a tireless and dedicated worker for the interests of medicine here in Cincinnati, both as Past President of the Academy and current President of the Midwest Foundation for Medical Care, Inc.

"The membership of the Academy of Medicine strongly supports Dr. Hogg's candidacy, and we feel that he will make an excellent President of our state organization."

Dr. Hogg received his medical degree from the University of Louisville in 1944 after which he served an internship at the U.S. Naval Hospital, Pearl Harbor, Hawaii. He also completed a residency in otolaryngology at the University of Cincinnati College of Medicine, Cincinnati General Hospital. He was certified by the American Board of Otolaryngology in 1950.

An Associate Clinical Professor of Otolaryngology at the University of Cincinnati College of Medicine, Dr. Hogg is in private practice in the specialty of ear, nose, and throat in Cincinnati. He is on the Attending Staffs at Cincinnati General, Children's, Christ, Bethesda, and Deaconess Hospitals, Cincinnati. He is on the Courtesy Staff of Good Samaritan Hospital, Cincinnati.

Dr. Hogg is currently serving the OSMA as First District Councilor. He is also President of the Midwest Foundation for Medical Care, Vice-President of the Regional Association of County Medical Societies, Delegate to the American Association of Foundations for Medical Care, and a member of the Board of Trustees Health Resources Coordinating Center and the Board of Trustees of the Cincinnati Speech and Hearing Center.

Dr. Hogg has also been President of the Cincinnati Academy of Medicine, the Ohio State Otolaryngology Society, and the Cincinnati Otolaryngology Society.

He is married to the former Carledean Taylor. They are the parents of six children, one of whom is deceased.



Stephen P. Hogg, M.D.



James C. McLarnan, M.D.



William M. Wells, M.D.

James C. McLarnan, M.D.

James C. McLarnan, M.D., of Mount Vernon, was nominated for the office of President-Elect of the OSMA by the Knox County Medical Society. Robert L. Westerbeide, M.D., Immediate Past President of the Knox County Medical Society, wrote:

"By constitutional privilege, the Knox County Medical Society nominates James C. McLarnan, M.D., for the office of President-Elect of the Ohio State Medical Association.

"He is qualified by membership in the Knox County Medical Society and the Ohio State Medical Association."

Dr. McLarnan graduated from The Ohio State University College of Medicine in 1951 and interned at Mercy Hospital, Toledo. Upon completion of his internship, he entered general practice in Mount Vernon until he undertook postgraduate study in anesthesia at The Ohio State University Hospitals. Following this study, Dr. McLarnan returned to Mt. Vernon where he established a private practice in anesthesia and obstetrics which he continued until 1973, when he limited his practice to anesthesia.

Dr. McLarnan has been quite active in the OSMA. He has been Councilor of the Tenth District, 1969-1975; member of the Auditing and Appropriations Committee, 1972-1975; member and Chairman of the Reference Committees on Resolutions, 1963-1970; Chairman of the Ad Hoc Committee on Legal Affairs; member of the Committee on Hospital Relations, the Committee on Legislation, the Advisory Committee to the Auxiliary, the Advisory Committee to the Ohio State Society of Medical Assistants, the Ohio Hospital Association Malpractice and Accident Prevention Advisory Committee, the Committee on Nursing, and the Committee on Private Practice.

At the local level, Dr. McLarnan has been President of the Knox County Medical Society; Delegate to the OSMA House of Delegates, 1963-1969; Chairman of the Legislative Committee; and member of the Executive Committee, 1963-1969.

Dr. McLarnan's medical specialty memberships include the Columbus Society of Anesthesiologists, the Ohio Society of Anesthesiologists, the American Society of Anesthesiologists, and the International Anesthesia Research Society.

Dr. McLarnan served as Knox County Coroner from 1957 to 1969. In 1964, he was President of the Ohio State Coroners Association and received an Honorary Life Membership from this organization in 1969. He is also a member of the National Coroners Association on whose Board of Consultants he served from 1959 to 1969. Dr. McLarnan is a member of AMPAC and is on the Board of Directors of OMPAC. He is also serving on the Board of Directors of the Knox County Health Planning Council and is a former member of the Ohio Hospital Advisory Council.

Dr. McLarnan served in the Army of the United States from 1945-1946 in Japan. His hobbies include amateur radio activities, golf, and boating. He is presently Radio Technical Chairman for the Mansfield Power Squadron. Dr. McLarnan is also quite active in various civic and social organizations in Mt. Vernon.

Dr. McLarnan is married to the former Marthella Glover Andrews. They have three children.

William M. Wells, M.D.

William M. Wells, M.D., of Newark, has been nominated for the office of President-Elect of the OSMA by the Licking County Medical Society. Michael P. Ratterman, M.D., President of the Licking County Medical Society wrote:

"By constitutional privilege, we are pleased to nominate William M. Wells, M.D., the Secretary-Treasurer of The Ohio State Medical Association, as a candidate for the office of President-Elect of The Ohio State Medical Association.

"Dr. Wells is qualified by membership in good standing in the Licking County Medical Society, the Ohio State Medical Association, and the American Medical Association."

Dr. Wells received his medical degree from The Ohio State University College of Medicine in 1942, where he became a member of Alpha Omega Alpha. Subsequently, he interned at University Hospital, Columbus, and also served as Junior Assistant in the Department of Surgery. Dr. Wells was in the United States Army serving in the European Theater of Operations during World War II.

He has established a family practice in Newark where he is a member of the Senior Staff of Licking Memorial Hospital. Dr. Wells served as Chief of Staff of the hospital from 1967 to 1968. He is also a member of the Board of Trustees of the Licking County Hospital Association.

The OSMA has received a great deal of Dr. Well's time. He has served as Eighth District Councilor, 1967-1973; Secretary-Treasurer, 1973-1976; Subcommittee Chairman on Government Medicine; Chairman of the Liaison Committee to Medical Assistants; Chairman of the Ad Hoc Committee Liaison to Podiatrists; and member of the Advisory Committee to Aid for Aged, the Auditing and Appropriations Committee, the Fee Review Committee, the Long Range Planning Committee, and the Liaison Committee to Ohio Medical Indemnity.

Dr. Wells has been President of the Licking County Medical Society and is a member of the Licking County Health Planning Council. He is also Vice-Chairman of the Board and Chairman of the Executive Committee of Ohio Medical Indemnity.

Dr. Wells, whose hobbies include golf and photography, is married to the former Roberta Seip. They have four children.



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential

status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.



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When **impotence** due to
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is driving them apart



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Tabs
Android-10 Oral
Tabs
Android-25 * Oral
Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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EACH ANDROID-G TABLET CONTAINS:

Methyltestosterone	1.25 mg
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L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg

Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

Anabolic Stimulant
Increased Muscular Tone
Osteoporosis

ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.



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Auxiliary Members Meet With Legislators

During March, members of the OSMA Auxiliary spent two days in Columbus learning about bills before both the House and Senate of Ohio. David L. Rader and D. Brent Mulgrew of the OSMA Department of State Legislation spoke at a dinner meeting of the Auxiliary.

The event's highlight was a luncheon attended by the Auxiliary members and many of Ohio's State Senators and Representatives. Among the legislators present were those pictured here and on this month's cover.

Legislators pictured with their constituents are (beginning in the one o'clock position and moving clockwise): Rep. Lawrence E. Hughes, Columbus; Rep. Francine M. Panehal, Cleveland, with David Rader; Sen. Charles L. Butts, Cleveland; Rep. Harry J. Lehman, Cleveland; lt. to rt.: Sen. Gene Slagle, Galion, Mrs. Ingrid May, chairman of the event, and Rep. Walter D. McClaskey, Marion; Sen. David W. Johnson, Canton.



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HOUR AFTER HOUR
AFTER HOUR AFTER
HOUR AFTER HOUR
AFTER HOUR AFTER
HOUR AFTER HOUR
AFTER HOUR AFTER
HOUR AFTER HOUR

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Ohio CME Accreditation Procedures

Douglas R. Houser, OSMA Coordinator of Continuing Medical Education

The purpose of this article is to familiarize the medical staffs of community hospitals, other institutions, and organizations with accreditation programs for continuing medical education (CME). The OSMA, in cooperation with the AMA, will survey (through questionnaire and site visits) and accredit continuing medical education activities for hospitals and other organizations.

CME refers to planned learning activities for physicians. Continued learning is a part of the professional life of every physician including experience in practice, ordinary relations with fellow practitioners (including formal and informal consultations), reading in professional journals and literature, attendance at society meetings or hospital staff meetings.

In recent years, the rapid increase of knowledge in medicine has made it clear that the physician needs formal CME for three principal reasons:

1. It is an efficient means for systematic coverage of new information and ideas so the busy clinician can use effectively the limited time available for continuing learning.

2. It encourages systematic attention to major needs as revealed by various analyses: surveys of community needs, shifts in hospital admission patterns, emergence of new techniques or knowledge that permit improved practice, and physician self-assessment techniques.

3. It permits maintenance of a permanent record of physician self-improvement efforts, and thus provides the basis for meeting formal requirements (eg, licensure, recertification) or other professional purposes (eg, the AMA or OSMA Physician's Recognition Award).

Any effective learning activity by physicians can constitute CME. The key word here is effective, ie, a program planned so that it is possible to document that, in fact, the activities have helped MDs to improve their knowledge, skills, and/or attitudes leading to improve patient care.

"Credit" refers to time spent in learning activities, measured in clock hours. If a hospital offers a weekly lecture-discussion meeting for a full hour, extending over 40 weeks of the year, any physician who attends all sessions would earn 40 hours of CME credit. If he attends only 22 of the sessions, he would earn 22 hours of CME credit. Thus, accurate participation records are important.

Accreditation is official recognition by the OSMA and the AMA Council on Medical Education that a program of continuing education for physicians is of high quality.

Broadly speaking, the AMA accredits medical schools and other organizations serving physicians from several states. OSMA accredits intra-state hospitals and organizations/institutions.

There is no difference between AMA and OSMA accreditation. OSMA operates under the authority of the AMA Council on Medical Education and its Advisory Committee on CME. Accreditation by OSMA is equivalent to action by AMA. The reason for a state program is to divide the workload between AMA and component state and territorial societies.

The process of gaining accreditation provides opportunity for review (by the hospital and by the surveyors) of the quality of CME activities. Hence, it provides an incentive to make changes and/or improvements as may be indicated. The Physician's Recognition Award (PRA) requires that at least 60 of the 150 hours prescribed in a three-year period must be in Category 1-accredited CME programs.

An organization accredited by the OSMA Commission on Medical Education may designate which of its CME activities meet the criteria for Category 1. In sponsoring or cosponsoring a CME program, an accredited organization must be sufficiently involved in the planning, development, administration, and evaluation of the program to assure that it meets the definition of a planned program of CME, and must accept full responsibility for its educational value.

It is inappropriate for an accredited institution or organization to agree to cosponsorship of a continuing education activity when it does not fulfill the responsibilities of an accredited cosponsor. Accredited cosponsorship cannot be delegated or made a "rubber stamp" procedure. To do so would place the organization's accreditation for CME in jeopardy.

For the purposes of Category 1, a planned program of CME is one having sufficient scope and depth of coverage to form an education unit that is planned, coordinated, administered, and evaluated in terms of specific educational objectives, such as a defined level of knowledge or a specific performance skill to be attained by the physician participating in the program. It is the responsibility of the accredited sponsor or cosponsor of a CME program to be certain that the program meets the definition of a planned program of CME.

To the extent possible, educational objectives should be based upon CME needs. Where group or individual CME needs cannot be based on a practice, profile, peer review, self-assessment, case audits, etc., newly developed medical knowledge is often used as a basis for developing the educational objectives that are specific for a knowledge level or performance capability.

Because of the increasing importance of Category 1 CME to physicians, it is vital that accredited organizations maintain, protect, and enhance the quality of CME activities they designate as meeting the criteria for

(continued on page 208)

CME Accreditation (continued)

Category 1. To meet this objective, physicians participating on survey teams for reaccreditation are asked to describe, evaluate, and make recommendations concerning the manner in which accredited organizations have used their responsibility for designating which of their CME activities meet the criteria for Category 1. The Commission on Medical Education will pay particular attention to this part of the report in determining whether the institution's accreditation for CME should be continued.

Medical educational organizations sponsoring CME programs, which have not had an opportunity to become accredited, may seek to have their programs accepted in Category 1 by arranging for cosponsorship by an accredited organization. In some instances, accredited organizations have been asked to "rubber stamp" a program for which they have not had an opportunity to fulfill their obligation as an accredited cosponsor. This is inappropriate and may seriously jeopardize the quality of CME received by physicians seeking Category 1 credit.

Any hospital, territorial or specialty society, or group of physicians may gain accreditation, regardless of number of members or size of budget. The essential requirement is that the program be well organized. Learning objectives best for a local situation should be selected. OSMA considers only (1) whether those objectives are realistic and valid from a learning viewpoint, and (2) how well the program achieves them.

OSMA encourages the formation of consortia and other cooperative arrangements for continuing education purposes. A consortium offers three advantages: (1) makes it economically feasible to hire a director of CME and necessary supporting staff, (2) makes available a wider variety of teaching resources, and (3) makes possible programs for the less numerous specialists (eg, urologists, radiologists, pathologists, psychiatrists).

Following AMA practice, the Ohio Program accredits institutions or organizations, *NOT* specific

courses or other activities. Accreditation, if granted begins on the date when the Commission on Medical Education approves a site team visit report. Retroactive accreditation is specifically interdicted by the AMA Council on Education. To begin the accreditation process, the applicant submits an application and pays an Application Fee of \$50.00 to cover the cost of establishing a record file.

Each institution or organization that is surveyed will be notified by the Commission on Medical Education whether or not it has been accredited.

An additional \$50.00 is payable upon completion of site visit for accreditation. The expenses of the site visitors, to include travel and food, will be covered by the institution requesting accreditation.

There are five types of accreditation:

(1) Full accreditation of the institution or organization.

(2) Accreditation of the institution or organization contingent upon stipulated changes in the program.

(3) Provisional accreditation of an institution or organization. (Applicable only to newly developed programs and with a time limit of one or two years.)

(4) Accreditation only of certain courses within an institution or organization, rather than the entire institution. (This classification is to be given in cases where courses given by one department or branch are of high quality, while those given by other areas of the institution or agency are not of comparable quality to merit accreditation.)

A "certificate of accreditation" shall be provided to an institution or organization that is granted accreditation. The certificate shall specify the type of accreditation and the years for which it is granted. The institution or organization will be entitled to indicate on continuing education programs the type of accreditation approved for their institution.

EDITOR'S NOTE: The Continuing Medical Education section of *The Journal* which lists courses will return during the summer. It is presently being revamped.



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Art Show Planned

FOR 1976 OSMA ANNUAL MEETING

Space will be provided at the 1976 Annual Meeting of the Ohio State Medical Association, May 10, 11 and 12, at the Cincinnati Convention Center for a Physician's Art Show. The Art Show will be under the direction of Harry H. Fox, M.D., local Cincinnati physician as well as, Chairman of the Art and Culture Committee of the Medi-Club of the Academy of Medicine of Cincinnati. Dr. Fox directed the outstanding 1972 Art Show held in Cincinnati.

Members of the OSMA, their wives (or husbands), who are interested in exhibiting art pieces (they personally have created) or who require information regarding the exhibit, should fill out the application included below without delay.

It will be the responsibility of each exhibitor to see that his work gets to the Cincinnati Exposition Center. Final arrangements will be taken care of by a committee.

The OSMA will provide suitable display facilities, but each physician and/or wife is responsible for transportation costs and any other such expense involved in entering his or her exhibit. Art show security will be on duty.

Exhibitors will be limited to two art pieces per category.

An Art Award Committee will judge the exhibit competitively.

We solicit your exhibits to make the 1976 Art Show an outstanding success.

Application for Space in Art Show Exhibit

Mail to: Harry H. Fox, M.D., Chairman
1976 OSMA Art Show Committee
19 West Eighth
368 Doctors Building
Cincinnati, Ohio 45202

Name _____

Address _____

City _____ Zip Code _____

Phone No. _____

	Title	Dimensions	Value*
(a) Paintings (watercolor)	1. _____	_____	_____
	2. _____	_____	_____
(b) Paintings (oil or acrylics)	1. _____	_____	_____
	2. _____	_____	_____
(c) Sculpture	1. _____	_____	_____
	2. _____	_____	_____
(d) Photo-Arts (preferably mounted to hang)	1. _____	_____	_____
	2. _____	_____	_____
(e) Crafts (variable)	1. _____	_____	_____
	2. _____	_____	_____

Other information (which you believe will be helpful to the Art Show Committee).

(*Please include a fair market value for insurance)

Informed Consent: The Doctor's Dilemma & H.B. 682

D. Brent Mulgrew, J.D., OSMA Asst. Director of State Legislation
James E. Pohlman, J.D., OSMA Legal Counsel

George Bernard Shaw wrote *The Doctor's Dilemma*, a play about a physician who had to choose between curing a poor-but-honest physician or a brilliant-but-amoral artist. In July 1975, the Ohio General Assembly enacted Am. Sub. H. B. 682, the Omnibus Medical Malpractice Act, which places the Ohio physician in a different but happier dilemma: whether or not to utilize the provisions of the Act to discharge his legal responsibility of obtaining an "informed consent" from his patient. This article briefly examines the law with respect to "informed consent" and discusses the choices available to the physician, particularly those made possible by the enactment of H. B. 682.

Despite the testimony offered by representatives of plaintiffs' lawyers during the General Assembly's consideration of H. B. 682 to the effect that "informed consent" claims were insignificant in the overall medical malpractice picture, much attention has been centered on the subject during the current medical malpractice "crisis" and, for that matter, since 1960 when the first two of the modern cases on "informed consent" were decided.^{1,2}

The newer "informed consent" cases are, as Professor Plant of the University of Michigan Law School points out, only modern variations on an ancient theme. Professor Plant writes:

"For centuries it has been held that a person who occupies a relationship of trust and confidence with another, such as that existing between a physician and his patient, is liable for harmful misrepresentation, whether by affirmative statement or by nondisclosure, whether the falsity was intentional or arose through negligence."³

The "informed consent" doctrine is rooted in the classic statement by Justice Cardozo:

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."⁴

Or, as has been recently stated in the only reported "informed consent" case in Ohio: "Every competent person is the final arbiter of whether or not he gets cut, by whom he gets cut, and where he gets cut."⁵

The other side of the coin of the patient's right of bodily integrity is the rule of law holding that a physician who treats or operates upon a patient without authority to do so commits an assault and battery for which he may be prosecuted criminally or held civilly liable.⁶ Sound advice to the physician seeking to avoid

such liability has been given in an excellent text authored by both a physician and a lawyer:

"Usually authority to treat or operate arises from the valid consent of the patient or someone authorized to act in his behalf. The consent given may be either expressed or implied and, if expressed, it may be either written or oral. In the case of surgery or the utilization of any hazardous procedure, written authorization should be obtained. The consent should be broad enough to cover everything contemplated as likely to be required, but the so-called 'blanket consent form' is to be avoided."⁷

It should be emphasized that the physician's legal obligation of obtaining an informed consent can be satisfied only by proof that the procedure involved and its risks were explained to the patient in understandable, nontechnical terms. In short, the physician's defense of an "informed consent" claim is predicted upon actual communication between him and his patient. The use of written consent forms in his practice only serves to arm the physician with proof that in fact such communication took place before the surgery or treatment was commenced in the inevitable "swearing match" that takes place in the courtroom in an "informed consent" case. As such, a written consent form is an invaluable aid to the physician and his counsel in defending an "informed consent" claim. However, it is neither an absolute defense or bar to the patient's claim nor a substitute for actual communication between the physician and his patient.

When should the physician rely upon the statutory provisions of H. B. 682? The clear benefit to the doctor who uses and relies upon a written form authorized by H. B. 682 is that in the absence of evidence of fraud by the physician or a language disability by the patient, it "shall . . . be presumed to be valid and effective" in a civil action based upon an "informed consent" claim.⁸ The new statute sets forth two alternatives for use by the doctor: either a written consent conforming to the provisions of divisions (A), (B) and (C)⁹ or a written form conforming to the specific provisions of division (D).¹⁰ It will be noted that either of these alternatives under the statute will probably be limited in practice to procedures involving surgery or the utilization of hazardous procedures, whether diagnostic or therapeutic. The use of a statutory form would not appear to be appropriate in the cases of minor surgery or routine medical practice in which the risks of death or quadriplegia, for example, would not be material.

Since the practice of physicians varies so widely, each physician should consult his own legal counsel for

advice both as to whether a written consent form following one of statutory alternatives should be used and, if so, the appropriate form to use in connection with any particular procedure or treatment. Where it is determined that it is not advisable to use a written consent form authorized by H. B. 682 in the physician's practice, it is suggested that consideration be given by the physician and his counsel to other means (such as notations made by the physician either in the progress notes of the hospital chart or in the patient's office chart immediately following the discussion between him and his patient) of documenting the disclosure by the physician to his patients of the risks and hazards.

Certain areas of medical practice, eg, the surgical specialties, radiology, and obstetrics/gynecology, obviously lend themselves to greater utilization of and reliance upon the written consent forms authorized by H. B. 682 than do other areas such as family practice, internal medicine, and pediatrics.

In conclusion, H. B. 682 offers the physician new alternatives that may be useful in establishing valid and effective defenses in "informed consent" claims. The extent to which it may be successfully relied upon by the physician and his counsel will, of course, vary from case to case, but the statute should become an important weapon in the physician's arsenal against the onslaught of "informed consent" claims that seems certain to continue.

References

1. *Mitchell vs Robinson*, 334 SW 2d 11 (Missouri S Ct 1960).
2. *Natanson vs Kline*, 186 Kan 393, 350 P 2d 1093, modified 187 Kan 186, 354 P 2d 670 (1960).
3. Plant, ML: Informed consent—a new area?, in Shapiro ED, Steingold D, Needham R (eds): *Medical Malpractice*, Ann Arbor, Institute of Continuing Education, 1965, pp 29-42.
4. *Schloendorff vs Society of New York Hospital*, 211 NY 125, 105 N E 92 (1914).
5. *Congrove vs Holmes*, 37 Ohio Misc 95, (Ross C P 1973).
6. An exception to the general rule is recognized in emergency medical situations. See, for example, Louisell DW, Williams H: *Medical Malpractice*, New York, Matthew Bender, 1973, section 9.05.
7. Moritz AR, Morris RC: *Handbook of Legal Medicine*, ed 3, St. Louis, C V Mosby, 1970, p 119.
8. *Ohio Revised Code* Sec 2317.54.
9. Divisions (A), (B) and (C) of R. C. Sec. 2317.54 provides as follows:

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, together with the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures, with the probability of each such risk if reasonably determinable.

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, infancy, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances.

(continued on page 212)



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Informed Consent (continued)

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- | | COMMENTS |
|--|----------|
| ☐ Death | |
| ☐ Brain damage | |
| ☐ Quadriplegia (paralysis of all arms and legs) | |
| ☐ Paraplegia (paralysis of both legs) | |
| ☐ Loss of organ | |
| ☐ Loss of an arm or leg | |
| ☐ Loss of function of organ | |
| ☐ Loss of function of an arm or leg | |
| ☐ Disfiguring scars | |

The doctor has explained to me the most likely complications or undesired results that might occur in this operation or medical procedure AND I UNDERSTAND THEM. The doctor has offered to detail the LESS LIKELY COMPLICATIONS OF UNDESIRE RESULTS which even if rare, could occur.

....I do I do not wish to have a full description of all the possible complications given to me.

I hereby authorize and direct the above named physician with associates or assistants to provide such additional services as they may deem reasonable and necessary including, but not limited to, the administration of any anesthetic agent, or the services of the x-ray department or laboratories, and I hereby consent thereto.

I hereby state that I have read and understand this consent and that all blanks were filled in prior to my signature.

Date: Time: a.m. p.m.
Signature of Patient
Signature of Relative (where required)
Signature of Representative (where required)
Witness

I certify that I have personally completed all blanks in this form and explained them to the patient or his representative before requesting the patient or his representative to sign it.

10. Division (D) of R. C. Sec. 2317.54 provides as follows.

(D) The consent is in ten-point type and is executed in the following form:

CONSENT FOR MEDICAL PROCEDURE AND ACKNOWLEDGMENT OF RECEIPT OF RISK INFORMATION

State law requires us to obtain your consent to your contemplated surgery or other medical procedure. What you are being asked to sign is simply a confirmation that we have discussed your contemplated operation or medical procedure and that we have given you sufficient information upon which to make a decision whether to have the operation or medical procedure and any choice as to the type of operation or medical procedure of your own free will. We have already discussed with you the common problems or undesired results that sometimes occur. We wish to inform you, not to alarm you. If you wish, however, we can go into more elaborate details of more unlikely problems. If you do not, that is also your privilege. Please read the form carefully and check the appropriate boxes. ASK ABOUT ANYTHING THAT YOU DO NOT UNDERSTAND. We will be pleased to explain it. I hereby authorize and direct, with associate or assistants of his choice to perform the following surgical, diagnostic, or medical procedure on, my, as we have agreed upon.

Relationship

.....
I further authorize the doctors to perform any other procedure that in their judgment is advisable for my well being. Details of this operation have been explained to me. Alternate methods of treatment, if any, have also been explained to me as have the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that therefore there can be no guarantee as expressed or implied either as to the result of surgery or as to cure.

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abort migraine
and cluster headaches

potential of further distress to migraine patients whose associated symptoms include nausea." Ergotamine tartrate

in a micronized saliva-soluble form (Ergomar) has been used in our clinic on 334 patients . . . It has all the advantages of the oral form of administration because of its ease and convenience of administration without the slower action and nauseating potential . . ."¹

1. Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976. See reverse side for prescribing information.

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☐ Proceedings of the Vascular Headache Symposium (Printed)	☐ Patient Information Booklets
☐ Reprint of Abortive Therapy for Vascular Headaches (Consultant 16:156-165, 1976)	☐ Trial Supply of Sublingual ERGOMAR® Tablets (ergotamine tartrate, 2 mg.)

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Precautions and Contraindications: Avoid prolonged administration or dosage in excess of that recommended because of the danger of ergotism and gangrene. Contraindicated in sepsis, occlusive vascular disease (thromboangiitis obliterans, luetic arteritis, severe arteriosclerosis, coronary artery disease, thrombophlebitis, Raynaud's disease), hepatic disease, renal disease, severe pruritus, and pregnancy.

Side Effects: No serious complications have been reported from the use of Ergomar (ergotamine tartrate) in the

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most convenient way to
abort the pain
of migraine
or cluster headaches

absence of contraindications and in recommended dosages. Unpleasant side effects which may occur include nausea and vomiting, weakness in the legs, muscle pains in the extremities, numbness and tingling of fingers and toes, precordial distress and pain, and transient tachycardia or bradycardia. Localized edema and itching may occur in the rare sensitive patient. Side effects are usually not such as to necessitate interruption of therapy.

Administration and Dosage: All efforts should be made to initiate therapy as soon as

possible after the first symptoms of the attack are noted, since success is proportional to rapidity of treatment, and lower dosages will be effective.

At the first sign of an attack, or to relieve the symptoms of the full-blown attack, one tablet is placed under the tongue. Another tablet should be taken at half-hourly intervals thereafter, if necessary, but dosage must not exceed three tablets in any 24-hour period. Limit dosage to not more than 10 mg. in any one week.

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The Stabilization Reserve Fund

Layton C. Severson, Manager, JUA Operations

The Stabilization Reserve Fund portion of Amended Sub. House Bill No. 682 deals with creating a separate reserve fund to be used in the event that premiums charged for policies are not adequate to cover all claims.

Section 3929.74 (A through H) creates, defines, and gives specific instructions regarding the statute which is referred to as "Stabilization Reserve Fund."

Section 3929.74 (A) states "... there is hereby created a Stabilization Reserve Fund. The Fund shall be administered by three directors, one of whom shall be the Superintendent of Insurance or his deputy. One of the remaining directors shall be a physician appointed by the Superintendent. The remaining director shall be a representative of a hospital appointed by the Superintendent ..."

While it is a difficult concept for the individual physician and health care provider to deal with, the Stabilization Reserve Fund should not be confused with "premiums" charged for policies issued by the Joint Underwriting Association.

The Stabilization Reserve Fund was created so that the assessment factors of the law could, hopefully, be avoided and used only as a final effort for rejuvenating depleted premium and reserve fund.

The Stabilization Reserve Fund is run by the three directors as noted above, and the only factor that involves the Ohio Medical Professional Liability Underwriting Association is the collection and depositing of monies into this fund. The Joint Underwriting Association has nothing to do with the operation of the Stabilization Reserve Fund.

The Stabilization Reserve Fund is a "matching" fund in the sense that the individual doctor matches the premium up to a maximum limit of \$5,000 per primary policy. The law states "... the charge shall be equal to the total primary premium payment subject to a \$5,000 maximum per physician and an \$8,000 maximum per hospital. In the event a policy holder purchases only excess insurance coverage from the Association, the

charge shall be equal to 25 percent of the total excess premium payment, subject to a \$750.00 maximum per physician and a \$5,000 maximum per hospital.

In addition to funds collected from insureds of the Ohio Medical Professional Liability Underwriting Association, this fund surcharge applies to all other professional liability policies written by another insurer. The limit on policies issued by other insurers is \$250.00 per policy.

Therefore, while the Joint Underwriting Association writes a policy with a matching Stabilization Reserve Fund, all other carriers who write medical professional liability must also contribute on any policy that they write through their individual company subject to a \$250.00 limit for individual physicians and a \$15,000 limit for individual hospitals.

The Stabilization Reserve Fund has a maximum ceiling of \$40,000,000 placed on it by statute. If the Fund exceeds the sum of \$40,000,000 at the end of any fiscal year (exclusive of dollars allocated for pending claims and after payments of all claims and surcharges), the Superintendent of Insurance may reduce the surcharge to Association policy holders and the amount collected from other malpractice insurers for each malpractice policy issued by them.

This means that in the event the Fund ever "tops out," the Fund charges may be reduced or dropped completely. In the event that the Fund is successful as a back-up system and a stabilization mechanism, it is anticipated that at some future date there may be a return of the balance left in the Fund to the individual participants of the Fund on a straight pro-rata basis. However, the Fund will not be distributed until all claims pending and anticipated have matured.

If there are any questions regarding the Stabilization Reserve Fund and how it operates, the individual should feel free to write or call us at our office, 1880 E. Dublin-Granville Road, P.O. Box 2638, Columbus, Ohio 43216, Phone: 614/891-5400 or Ohio Wats 1-800-282-8817.

NOTE: In order to identify funds contributed to the SRF, it is necessary for the JUA to have either a physician's Social Security number or his Corporation Identification number. If the SRF is discontinued, these numbers will ensure that any funds returned are returned to the proper individuals.



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Amitriptyline Poisoning Causing Left Bundle Branch Block

Yune-Gill Jeong, M.D.
Leonard P. Caccamo, M.D.

A patient with mental depression developed transient left bundle branch block (LBBB) secondary to an amitriptyline hydrochloride, 5-(3-dimethylaminopropylidene)-dibenzo [a,d] [1,4] cycloheptadiene hydrochloride, intoxication as a suicidal attempt. A review of the literature uncovered six additional cases of LBBB during amitriptyline hydrochloride intoxication or treatment. Amitriptyline hydrochloride poisoning or treatment has been associated with EKG changes of transient autonomic dysfunction and, in several incidents, even sudden death.

SINCE THE INTRODUCTION of tricyclic antidepressants in 1957, clinical use of amitriptyline hydrochloride has increased progressively and reports concerning cardiotoxicity have been published. A review of the English medical literature has revealed only a few reported cases of left bundle branch block (LBBB) due to amitriptyline hydrochloride poisoning, but the exact mechanism of the LBBB is still uncertain. The cardiotoxicity of amitriptyline hydrochloride poisoning has been considered to be related to three factors: the anticholinergic, atropine-like effect on the conduction system,¹ a direct sympathomimetic effect on the myocardium,² and blockade of the uptake and release of norepinephrine at the peripheral sympathetic adrenergic terminals with concomitant elevation of plasma catecholamine levels.¹⁻³ The development of a transient LBBB following self-in-

duced amitriptyline hydrochloride poisoning followed by spontaneous recovery is presented.

A 61-year-old white man was admitted to the hospital emergency room approximately nine hours after ingesting 1,000 mg of amitriptyline hydrochloride. The patient was a known manic depressive. Therapy for this condition involved a combination of amitriptyline hydrochloride and electroshock treatments.

Physical examination on admission revealed a patient deeply comatose and unresponsive to painful stimulation. The blood pressure was 180/108 mm Hg; pulse, 112 beats per minute and regular; respirations, 28 per minute; temperature 36.7 C (98 F); and weight 86.3 kg (190 lb). The pupils were dilated and fixed, and the optic fundi revealed arteriolar narrowings. All extremities were flaccid but pathologic reflexes were absent. The lungs were clear to auscultation and percussion. No heart murmurs or gallops were heard.

There was a past history of duodenal ulcer in 1950; appendicitis with perforation and peritonitis in 1968; diabetes mellitus since 1966 which was controlled with diet only; and posteroinferior cerebellar artery syndrome in January of 1972. Prior to the present admission, his blood pressure was 139/90 mm Hg and electrocardiogram (EKG) was within normal limits. (See Figure.) He did not use tobacco or alcohol.

On admission, the hematocrit reading was 45.6 percent, and the white blood cell count (WBC) was 13,000/

cu mm, with 90 percent segmented cells and 10 percent lymphocytes. Result of urinalysis was normal. Blood urea nitrogen (BUN) was 13 mg/100 ml; serum bicarbonate, 30 mEq/liter; serum chloride, 100 mEq/liter; serum sodium 132 mEq/liter; and serum potassium, 4.8 mEq/liter. A sinus tachycardia of 100 beats per minute, left axis deviation, complete LBBB, clockwise rotation and nonspecific ST and T wave changes were seen on the EKG (Figure). Chest roentgenogram revealed no abnormalities. He was treated with dexamethasone sodium phosphate, 20 mg per day. Ten hours after admission, the patient awakened; his blood pressure was 131/75 mm Hg and remained at this level. He showed dysarthria, dysphagia, nystagmus, and hallucinations over the next several days, and anticoagulation treatment was begun. The patient also developed upper abdominal pain, and x-ray films of the gallbladder revealed the presence of cholelithiasis.

Six days following admission, the EKG showed occasional premature ventricular contractions and nonspecific ST and T wave changes, and the LBBB had disappeared (Figure). The heart rate on the EKG was 94 beats per minute. Ten days after admission, he was completely recovered and was eventually discharged on a regimen of diazepam, 5 mg three times a day; crystalline sodium warfarin, 5 mg per day; phenformin hydrochloride, 100 mg per day; and a diabetic diet. Electroshock therapy was discontinued from this patient's treatment schedule because of his cerebrovascular status.

The LBBB has not recurred in follow-up EKG including the most recent tracing taken 24 months after the original incident.

Discussion

Since the accidental discovery of the antidepressive properties of tricyclic antidepressants, there has been a marked increase in the use of amitriptyline hydrochloride in clinical medicine. The potential cardiac toxicity of this drug deserves adequate consideration.

The cardiotoxic actions of amitriptyline hydrochloride involve both the conduction system and the cardiac muscle. The conduction system effect is due to the drug's atropine-like anticholinergic properties.¹ The myocardial effect is related to sympathomimetic properties which activate β -adrenergic receptors and cardiac glycogen phosphorylase.² The actions on the sympathetic

adrenergic transmission processes are complex and may vary in opposite direction depending upon the dose level of the drug. Amitriptyline hydrochloride in low doses potentiates the peripheral actions of norepinephrine by interfering with the uptake and storage of norepinephrine in peripheral nerve tissues. At high dosage levels, this action disappears and is replaced by an inhibitory effect, β -receptor blockade properties.

In acute poisoning, the EKG changes reported are flattening of T waves, depression of ST segments, prolonged QT intervals, and arrhythmias, such as sinus tachycardia, wandering pacemaker, supraventricular tachycardia, atrial fibrillation, premature ventricular contractions, ventricular fibrillation, atrioventricular block, and bundle branch block.⁴⁻⁹ Most authors consider these changes as benign without pathologic significance, with the exception of ventricular fibrillation, and reversible when the drug is discontinued.

Increased plasma levels of catecholamines, direct sympathomimetic effect on the myocardium, and anticholinergic atropine-like effects with amitriptyline hydrochloride poisoning can produce a serious disturbance in autonomic balance with a shift toward adrenergic dominance. This appears to be the most likely mechanism responsible for the tachycardia, arrhythmia, and temporary elevation of the blood pressure by the drug. In the six previously reported cases of LBBB, the pulse rates during the LBBB were recorded in only three cases, and they were 90, 100, and 150 beats per minute, respectively. No comment was made regarding the heart rate after disappearance of the LBBB. In the report presented herein, the patient's heart rate was 100 beats per minute during the LBBB and 94 beats per minute six days later, when the EKG was normal. It is conjectural whether the LBBB was produced by an increased heart rate (rate-dependent bundle branch block), by blockade of the adrenergic receptors due to high tissue levels of the drug in the myocardium, or by still other unrelated, unidentified mechanisms. Thus, the exact cause of the LBBB during amitriptyline hydrochloride poisoning remains unexplained.

Summary

There are only a few reports available on the management of complications resulting from acute amitriptyline hydrochloride poisoning. Pyridostigmine bromide and neostigmine methylsulfate appear to be the best drugs to reverse the EKG abnormalities,¹⁰ while others suggest propranolol hydrochloride, digoxin, a forced alkaline diuresis, and chlordiazepoxide hydrochloride. The patient presented in this article recovered with only supportive measures, and the EKG became normal in six days.

The significantly high frequency of unexpected death and frequent occurrence of cardiotoxic manifestations during amitriptyline hydrochloride treatment or poisoning suggest that this drug should be used with caution, particularly in individuals with heart disease or

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Dr. Jeong, Youngstown, Resident in Internal Medicine, St. Elizabeth Hospital.

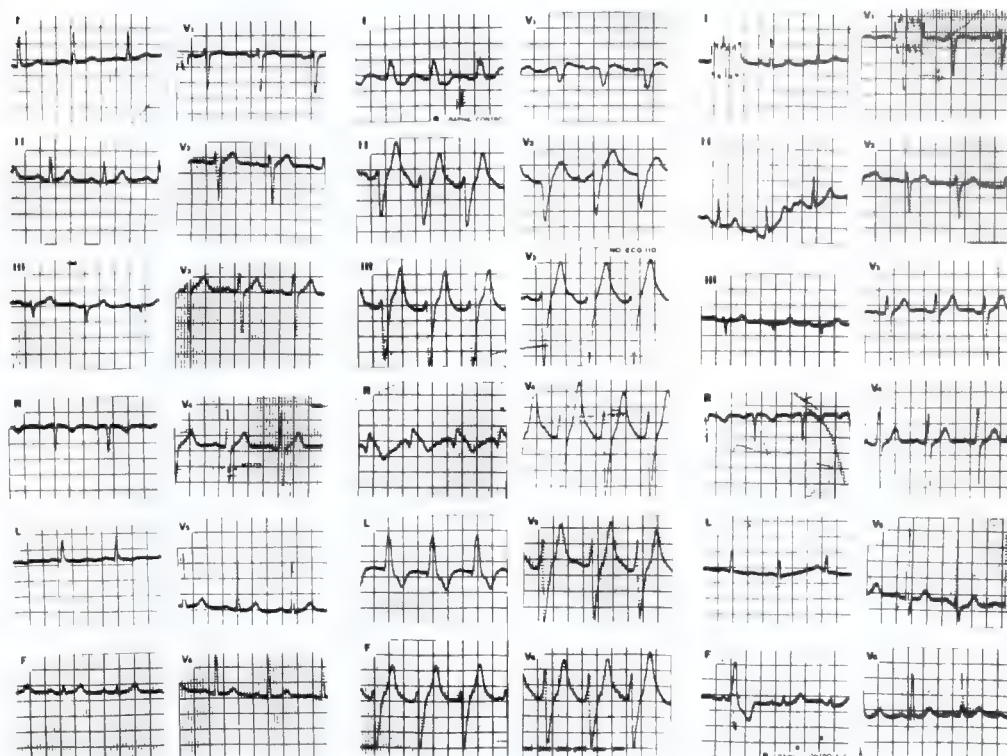
Dr. Caccamo, Youngstown, Director of Medical Education and Director of Coronary Care Unit, St. Elizabeth Hospital.

Submitted August 19, 1975.

Feb 10, 72

Apr 18, 72

Apr 24, 72



Electrocardiographic changes before (left), during (center), and after (right) amitriptyline hydrochloride poisoning.

those receiving drugs that deplete cardiac catecholamines.^{11,12}

Acknowledgment: E. Weltman, M.D. provided the clinical data for this paper.

Generic and Trade Names of Drugs

Amitriptyline hydrochloride—Elavil (Merck Sharp & Dohme)

Dexamethasone sodium phosphate—Decadron (Merck Sharp & Dohme)

Pyridostigmine bromide—Mestinon (Roche Laboratories)

Crystalline sodium warfarin—Coumadin (Endo Laboratories)

Phenformin hydrochloride—DBI-TD (GEIGY Pharmaceuticals)

Diazepam—Valium (Roche)

Neostigmine methylsulfate—Prostigmin (Roche)

Propranolol hydrochloride—Inderal (Ayerst Laboratories)

Digoxin—Lanoxin (Burroughs Wellcome Co.)

Chlordiazepoxide hydrochloride—Librium (Roche)

References

1. Cairncross KD: On the peripheral pharmacology of amitriptyline. *Arch Int Pharmacodyn Ther* 159:438-448, 1965.
2. Satchell DG, Cairncross KD, Freeman SE: The effect of

amitriptyline on glycogen phosphorylase in cardiac muscle. *Biochem Pharmacol* 13:1683-1685, 1964.

3. Titus EO, Matussek N, Spiegel HE, et al: The effects of desmethylinipramine on uptake of dl-norepinephrine-7-H³ in the heart. *J. Pharmacol Exp Ther* 152:469-477, 1966.
4. Alexander CS, Nino A: Cardiovascular complications in young patients taking psychotropic drugs. A preliminary report. *Am Heart J* 78:757-769, 1969.
5. Brackenridge RG, Peters TJ, Watson JM: Myocardial damage in amitriptyline and nortriptyline poisoning. *Scott Med J* 13:208-210, 1968.
6. Sorensen NS, Adreassen J: Amitriptylinforgifting. *Ugeskr Laeger* 126:1395-1397, 1964.
7. Olsen A: Grenblok under behandling med antidepressive. *Ugeskr Laeger* 125:395-397, 1963.
8. Kristjansen P, Poulsen H: Grenblok som bivirkning ved amitriptylinbehandling. *Ugeskr Laeger* 125:394-395, 1963.
9. Rasmussen EB, Kristjansen P: ECG changes during amitriptyline treatment. *Am J Psychiatry* 119:781-782, 1963.
10. Nymark M, Rasmussen J: Effect of certain drugs upon amitriptyline induced electrocardiographic changes. *Acta Pharmacol Toxicol (Kbh)* 24:148-156, 1966.
11. Moir DC, Cornwell WB, Dingwall-Fordyce I, et al: Cardio-toxicity of amitriptyline. *Lancet* 2:561-564, 1972.
12. Coull DC, Crooks J, Dingwall-Fordyce I, et al: Amitriptyline and cardiac disease. Risk of sudden death identified by monitoring system. *Lancet* 2:590-591, 1970.

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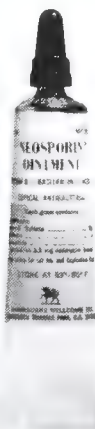
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Metastatic Hepatic Neoplasms

Detection by Liver Imaging and Liver Function Tests

Ranchhod S. Shah, M.D.
Gerald Stark, M.D.
Robert Stankey, M.D.
John H. Hughes, M.D.

From July 1970 through June 1972, at St. Vincent Hospital and Medical Center in Toledo, 1,379 examinations of the liver by radioisotopic scan were performed. Subsequently, the liver was examined directly at laparotomy or autopsy in 151 cases. Only 45 percent of patients with proven hepatic metastases had clinical hepatomegaly. The reliability of liver scan in the diagnosis of metastasis was 78 percent, with 11 percent false positive and 11 percent false negative results. Comparative reliability by determination of serum alkaline phosphatase was 56 percent and by serum glutamic oxaloacetic transaminase (SGOT) 48 percent.

RADIOISOTOPIC IMAGING of the liver has improved both in quality and use since its introduction by Stirrett et al¹ in 1954. By this technique, graphic recording of size, shape, and relative concentration of isotope of functioning liver tissue is obtained. Using radiocolloids, parts of the liver which are devoid of Kupffer's cells are revealed as areas of diminished activity. This technique frequently is employed to identify the presence or absence of intrahepatic neoplasia. This study was undertaken to determine the relative value of

both radioisotopic imaging of the liver and liver function tests in the diagnosis of intrahepatic neoplasia.

Materials and Methods

Patient selection.—From July 1970 through June 1972, at St. Vincent Hospital and Medical Center, an associated hospital of the Medical College of Ohio at Toledo, 1,379 patients underwent radioisotopic imaging of the liver. Patients were given intravenous injections of 250 microcuries of gold Au 198 colloid. Simultaneous anteroposterior and lateral views were obtained using either the Ohio-Nuclear Dual Probe 5-inch, crystal rectilinear scanner or the Searle Gamma Camera. Our study involves a retrospective review of 151 patients who had direct examination of the liver performed either at laparotomy, at autopsy, or both.

The presumptive diagnosis was established at laparotomy in 127 patients and at postmortem examination in 24 cases. Of the 127 patients on whom laparotomy was performed, a liver biopsy was performed on 39 of them. The cases consisted of the following groups:

Group 1 (cancer)	91 (60.2 percent)
Group 2 (noncancer-noncirrhosis)	48 (32.0 percent)
Group 3 (cirrhosis)	12 (7.8 percent)
	151 (100.0 percent)

In 91 patients with primary cancer, autopsy or laparotomy demonstrated hepatic metastasis in 40 of them. Of these, three had clinical jaundice and 18 (45 percent) had hepatomegaly. The sites of primary tumor are noted in the Table. The incidence of true negative scans was 45 percent; the incidence of true positive scans was 33 percent. There were 11 percent false positive

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Dr. Stankey, Toledo, Associate Clinical Professor of Radiology, Medical College of Ohio at Toledo; Chief, Nuclear Medicine Section, St. Vincent Hospital and Medical Center.

Dr. Hughes, Toledo, Assistant Professor of Surgery and Community Medicine, Medical College of Ohio at Toledo.
Submitted October 6, 1975.

Sites of Primary Tumor in Patients with Metastatic Liver Disease

Gastrointestinal	—	47
Genitourinary	—	15
Pancreas	—	13
Liver	—	4
Breast	—	5
Lung	—	2
Retroperitoneal	—	2
Gallbladder	—	1
Skin (melanoma)	—	1
Unknown	—	1
Total	—	91

scans and 11 percent false negatives. Thus, the reliability of radioisotopic imaging of the liver in predicting the presence or absence of metastatic intrahepatic cancer was 78 percent. Of the ten patients with false positive liver scans, documentation in two cases was by autopsy and by laparotomy in eight cases. Two patients had fatty metamorphosis of liver, one had intraperitoneal adhesions, and seven appeared to have a normal liver.

The findings of these 91 patients with a primary cancer were correlated with the results of the liver function tests. Of the 40 patients with liver metastasis documented at laparotomy or autopsy, serum alkaline phosphatase determination was performed in 34 patients. This value was elevated abnormally in 20 (56 percent) of these patients. However, it also was abnormally elevated in 9 of 40 patients (22.5 percent) without metastasis.

Of the 40 patients with documented liver metastasis, determination of serum glutamic oxaloacetic transaminase (SGOT) was made in 29 of them. Values were elevated in 14 patients (48 percent), however, it was also abnormally elevated in 15 of 34 patients (44 percent) without metastasis. Serum albumin value was below 3.0 gm/100 ml in 15 of 22 patients with metastasis and in 11 of 21 of those without metastasis. The serum bilirubin determination was above normal in 5 of 26 patients (19 percent) with proven hepatic metastasis.

Noncancer-Noncirrhosis Group.—In this group of 48 patients, absence of cancer or cirrhosis was determined by direct examination of the liver by either laparotomy or autopsy. In 14 of these 48 patients (29 percent), the operation involved cholecystectomy for cholelithiasis. The remainder of patients had a laparotomy for other reasons.

There were five patients in this group who had false positive scans. In one case, this was due to external compression from multiple leiomyoma of the uterus. In another, the gallbladder fossa was described as a filling defect. The cause was undetermined in the other three cases. There was one false negative scan in which a 2X1-cm, thrombosed hemangioma was not visualized.

Cirrhosis.—In 12 patients, liver cirrhosis was documented at laparotomy or autopsy. All had a moderate-to-large

amount of extrahepatic uptake on scanning of the liver. Nine (75 percent) patients had an enlarged liver, seven (58.3 percent) had jaundice, and three (25 percent) had false positive scans. The reason for these false positive results never was determined.

Discussion

Radioisotopic imaging of the liver is commonly performed in surgical practice to detect metastases from primary cancer, or in the differential diagnosis of such clinical situations as abdominal mass, hepatomegaly, or jaundice. More recently, scanning of the liver has been used for follow-up of cancer patients following cancer surgery² or after chemotherapy.³ The reliability of liver scan in detecting hepatic metastasis has been evaluated by several authors.⁴⁻¹¹ The pattern of metastatic disease in the liver usually is that of multiple, discrete, space-occupying lesions. At times, solitary areas of metastatic disease within the liver can be delineated. The errors of liver scanning, proven later by laparotomy or autopsy, fall into two categories: false positive and false negative. In our series, the causes of the false positive readings of the scannings were external compression, decreased isotope uptake in the gallbladder fossa, intraperitoneal adhesions, and presence of parenchymal disease. Covington's study of 1,000 liver scans described the same causes of false positive readings.⁴ The most common cause of false negative readings was a lesion less than 3 cm in diameter. Occasionally, however, lesions larger than 4 cm were not visualized. In our study, there were 11 percent false positive scans and 11 percent false negative scans. These figures are comparable to those recently published by Castagna et al.¹²

The majority of patients in whom false negative scans were obtained had normal liver function tests, implying that the functioning liver tissue was minimally involved. One patient had a malignant melanoma excised from the occipital region and was readmitted with hepatomegaly 16 months later. The liver scan revealed a 5-cm defect in the lower edge of the liver. Results of all liver function tests were normal. At laparotomy, a 5-cm nodule was found in the left lobe of the liver. We see no other way this lesion could have been diagnosed preoperatively. Andrews et al² concluded in their study that following resection of colorectal cancer, serial liver scans are valuable in detecting those patients with localized liver metastasis in whom partial hepatectomy might improve care. This probably is true with other neoplasms.¹³ The accuracy of liver scanning is enhanced if a preoperative, baseline scan is obtained and any suspicious areas are examined by the surgeon at the time of laparotomy.

At times, the results of liver scan might help to determine preoperatively whether an operation will be potentially curative* or palliative. Margolis et al¹⁴ con-

*Editor's Note. — Statistical studies often refer to survival rates as differentiated from cure rates. The editorial policy of this Journal would be to refer to survival rates. R.L.M.

cluded that patients with bronchogenic carcinoma, or patients with small-cell carcinoma should have liver scanning and peritonescopy with needle biopsy — to prove or disprove liver metastasis — because of their high metastatic potential.

In our study, the accuracy of liver scans in predicting the presence or absence of hepatic metastasis was 78 percent, as compared to the accuracy of the serum alkaline phosphatase determination and SGOT concentration of 56 and 48 percent, respectively. The figures compared well with those described by Castagna et al.¹² Their figures for accuracy were 73, 58, and 60 percent for scan, alkaline phosphatase, and SGOT, respectively.

We also found that the presence of multiple space-occupying lesions without associated increased extrahepatic uptake was useful in differentiating hepatic neoplasm from cirrhosis in 30 patients. All 12 patients with cirrhosis of the liver had moderate-to-large amounts of extrahepatic uptake on scanning the liver. Wilson et al¹⁵ noted this in their study and stressed the importance of looking for extrahepatic uptake in interpreting a given liver scan. Johnson and Sweeney¹⁶ evaluated the scans with regard to hepatic size, configuration, distribution of radioactivity, space-occupying lesions, and amount of uptake in marrow and spleen. They discussed several mechanisms that contribute to false positive scans and recommended that clues to their detection are found in the presence of significantly increased extrahepatic uptake. Although gold Au 198 colloid preparation was used in our study, we believe that other colloid preparations will behave in a similar manner. Wilson and Keyes¹⁷ studied the liver and spleen uptake ratio in liver scanning and found that simple visual categorization of relative uptake by the liver and spleen offered a useful diagnostic criterion with some differential diagnostic significance.

Selective arteriography was not performed on any patients in this study. Since this technique is invasive, more expensive, and more time consuming, liver scanning is technically easier and more readily available in most hospitals. Currently, the comparative value of these two types of diagnostic studies has not been fully evaluated.

Conclusions

1. Radiosotopic imaging of the liver can contribute significantly to the preoperative evaluation of patients with cancer.

2. The reliability of this technique in the diagnosis of hepatic metastases was 78 percent, with 11 percent false positive and 11 percent false negative results.

3. We found that prediction of liver metastases by serum alkaline phosphatase determination was 56 percent accurate and was 48 percent accurate by SGOT. Predicting the presence or absence of metastases by liver function tests is less accurate than liver scan. Liver scan

helps to delineate metastatic lesions located deep within the liver that are not visible during an exploratory laparotomy. Lesions less than 3 cm in diameter, however, still can be missed.

4. Liver scan is an excellent modality by which to document the response to chemotherapy and immunotherapy of patients with cancer. Obtaining a pretreatment liver scan as a baseline for comparison is advised for those patients with intra-abdominal neoplasms.

5. Liver scan itself does not reveal the nature of an abnormal area. A tissue diagnosis still must be established by biopsy.

References

1. Stirrett LA, Yuhl ET, Cassen B: Clinical applications of hepatic radioactivity surveys. *Am J Gastroenterol* 12:310-317, 1954.
2. Andrews JT, Cox KR, Hare, WS, et al: Liver scanning for the detection of metastases following colo-rectal cancer surgery. *Aust NZ J Surg* 43:66-72, 1973.
3. Witek JT, Spencer RP: Scan evidence of decrease in size of intrahepatic tumors after chemotherapy. A case report. *Gastroenterology* 67:516-518, 1974.
4. Covington EE: The accuracy of liver photoscans. *Am J Roentgenol Radium Ther Nucl Med* 109:742-744, 1970.
5. Czerniak P: Scanning study of 700 livers: evaluation of existing diagnostic procedures, *Medical Radioisotope Scanning*, vol 2, in *Proceedings of a Symposium, Athens*, 1964. Vienna International Atomic Energy Association, 1964, pp 401-430.
6. Gollin FF, Sims JL, Cameron JR: Liver scanning and liver function tests. *JAMA* 187:111-116, 1964.
7. Lin SR, Mansfield CM, Kramer S, et al: Liver scanning in patients with suspected or proven cancer. *Am J Roentgenol Radium Ther Nucl Med* 108:98-101, 1970.
8. McAfee JG, Ause RG, Wagner HN Jr: Diagnostic value of scintillation scanning of the liver. *Arch Intern Med* 166:95-110, 1965.
9. Nagler W, Bender MA, Blau J: Radioisotope photoscanning of the liver. *Gastroenterology* 44:36-43, 1963.
10. Poulouse KP, Reba RC, Deland FH, et al: Role of liver scanning in the preoperative evaluation of patients with cancer. *Brit Med J* 4:585-587, 1969.
11. Smith LB, Williams RD: The relative diagnostic accuracy of liver radioactive isotope photoscanning. *Arch Surg* 76:693-697, 1968.
12. Castagna J, Benfield JR, Yamade H, et al: The reliability of liver scans and function tests in detecting metastases. *Surg Gynecol Obstet* 134:463-466, 1972.
13. Longmire WP, Trout HH, Greenfield J, et al: Elective hepatic surgery. *Ann Surg* 179:712-721, 1974.
14. Margolis R, Hansen HH, Muggia FM, et al: Diagnosis of liver metastases in bronchogenic carcinoma: A comparative study of liver scans, function tests, and peritonescopy with liver biopsy in all patients. *Cancer* 34:1825-1829, 1974.
15. Wilson FE, Preston DF, Overholt EL: Detection of hepatic neoplasm. *JAMA* 209:676-679, 1969.
16. Johnson PM, Sweeney WA: The false-positive hepatic scan. *J Nucl Med* 8:451-460, 1969.
17. Wilson GA, Keyes JW: The significance of the liver-spleen uptake ratio in liver scanning. *J Nucl Med* 15:593-597, 1974.

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Congenital Absence of a Pulmonary Artery

John R. Hansel, M.D.
William H. Falor, M.D.

A case of unilateral absence of a pulmonary artery with anomalous systemic blood supply is presented, and therapy for this anomaly is discussed.

CONGENITAL ABSENCE of a pulmonary artery has been recognized for over 100 years. It may be defined as a complete absence of a pulmonary artery with an intact lung on the affected side. This anomaly may occur as an isolated lesion or in combination with other cardiac or vascular lesions.¹ The patient in this report had no cardiac defects, but he had a right aortic arch and an anomalous systemic artery arising from the abdominal aorta which, after passing through a sub-diaphragmatic, angiomaticous formation, entered the left pulmonary arterial system.

A 23-year-old man presented with the chief complaint of shortness of breath; he had no previous history of pulmonary complaints.

Physical examination showed asymmetrical development of the chest with a small left hemithorax. Breath sounds were normal, but there was minimal respiratory excursion to the left chest. The cardiac impulse was shifted into the left chest with no cardiac murmurs present. There was a continuous murmur present along the lateral left chest wall.

Chest x-ray film revealed a contracted left hemithorax with shift of the mediastinum to the left. The left pulmonary artery was absent and there was a right aortic arch present (Fig. 1). Electrocardiogram showed marked right axis shift and incomplete right bundle branch block. Differential bronchspirometry showed total lack of oxygen uptake from the left lung with a vital capacity of only 14 percent from the left lung. Arterial blood gases were normal.

Pressures recorded in the right heart and pulmonary artery were normal. There was no evidence of intracardiac



FIG. 1. X-ray film showing contracted left hemithorax with shift of mediastinum. Note right aortic arch.

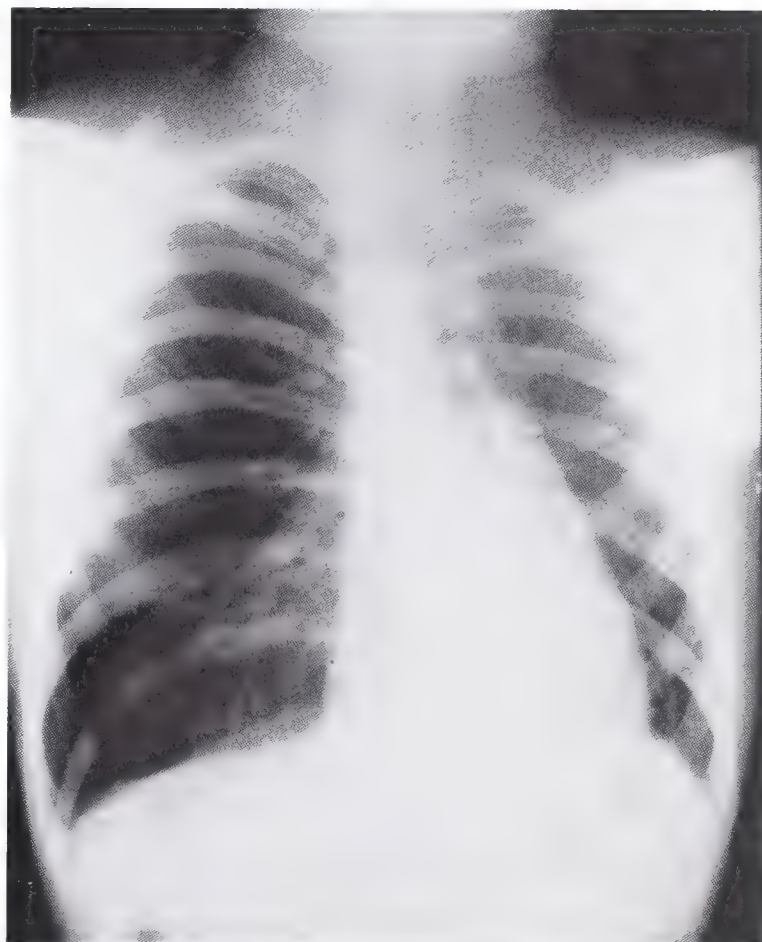


FIG. 2. X-ray film showing absence of left pulmonary artery.

From the Thoracic Surgical Service, Akron City Hospital, 525 E. Market St., Akron, Ohio.

Reprint requests to Lymph Research Laboratory, Akron City Hospital, 525 E. Market St., Akron, Ohio 44309 (Dr. Falor).

Submitted September 24, 1975.

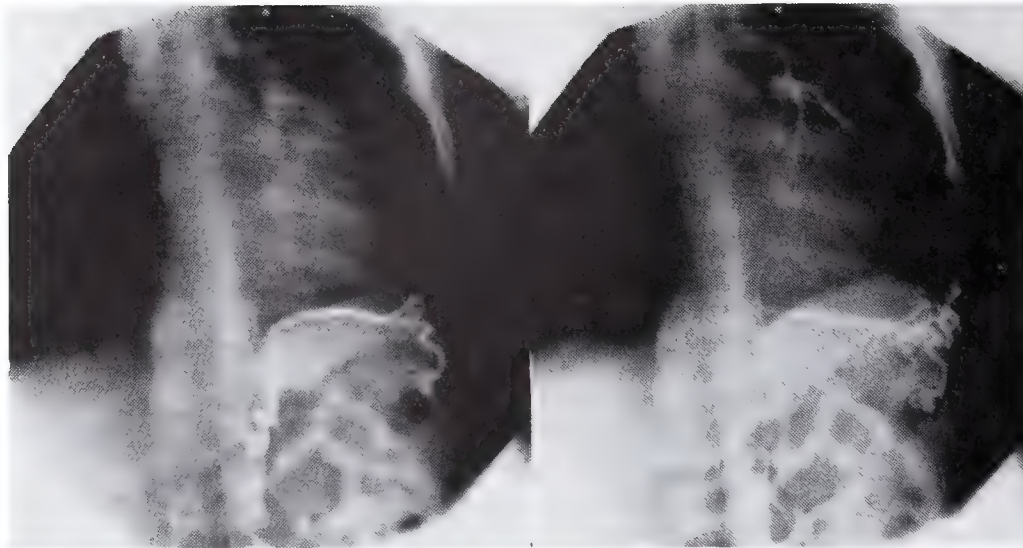


FIG. 3. Anomalous systemic artery arising from aorta (left) and communicating with left pulmonary arterial system through subdiaphragmatic, angiomatous formation (right).

shunt, and the cardiac index was 5.5 liters per minute per square meter. Pulmonary artery angiography confirmed the diagnosis of unilateral absence of the left pulmonary artery (Fig. 2). Findings of bronchoscopy and bronchography were normal.

Selective angiography of an anomalous systemic artery arising from the abdominal aorta and communication with the left pulmonary arterial system through a subdiaphragmatic, angiomatous formation are seen in Figure 3.

Discussion

The patient with unilateral absence of a pulmonary artery without intracardiac anomalies in the adult age group usually presents with the respiratory complaint of dyspnea. Some cases will present with recurrent respiratory infections or hemoptysis. This patient presented with dyspnea. The interesting feature of this case is the systemic blood supply to the affected lung. There are numerous theories to explain both unilateral absence of the pulmonary artery and the resultant blood supply to the affected lung, and many are based on embryologic principles.² Based on these principles, blood supply to the affected lung is derived from either bronchial arteries or a "duct-like" vessel from the aortic arch. We would have to classify the blood supply to this patient's affected lung as anomalous as it does not conform to any embryologic pattern.

Long-term observation of adults with unilateral absence of a pulmonary artery will be required to arrive

at proper therapy. The majority of adult patients with unilateral absence of a pulmonary artery will not have sufficient pulmonary artery in the hilus of the affected lung that is required for a revascularization procedure. Therefore, the advisability of pneumonectomy becomes paramount. At the present time, pneumonectomy is indicated in those patients for chronic recurrent pulmonary infection and hemoptysis. However, ventilation of a lung without gas exchange creates dead space and, thus, increases the total ventilatory requirement.³ Whether this increased ventilatory requirement will contribute to further respiratory insufficiency in the aging patient remains to be seen.

References

1. Pool PE, Vogel JHK, Blount SG Jr: Congenital unilateral absence of a pulmonary artery—the importance of flow in pulmonary hypertension. *Am J Cardiol* 10:706-732, 1962.
2. Finney JO Jr, Finchum RN: Congenital unilateral absence of the left pulmonary artery with right aortic arch and a normal conus. *South Med J* 65:1079-1082, 1972.
3. Shannon DC, Kazemi H: Distribution of lung functions in patients with anomalies of the pulmonary circulation. *J Thorac Cardiovasc Surg* 64:26-30, 1972.

Dr. Hansel, Akron, Junior Staff, Thoracic Surgical Section, Akron City Hospital.

Dr. Falor, Akron, Head, Thoracic Surgery Service, Akron City Hospital.

A Special Type of Theft

Jack M. Kenyon, M.D.

Persons who steal items of little monetary value and for no economic gain appear to derive no personal satisfaction from taking such objects. They usually are referred to the psychiatrist at the direction of the court or on the recommendation of their attorney. Some examples of these thefts are presented.

FREQUENTLY, OHIO'S COURTS refer cases of a special type of theft to psychiatrists for treatment. Because of the nature of the problem, the long-term outlook is unsatisfactory at times, and a medicolegal approach is recommended.^{1,2}

These thefts are characterized by the seeming lack of motivation, the small value of the objects taken, and the lack of either overt economical gain or personal satisfaction from taking the objects. They usually come to the attention of the psychiatrist through the court or the patient's attorney, and a few examples are cited.

A 46-year-old secretary was arrested for picking up small items of men's clothing in a department store. This was her first episode of being arrested for petty larceny. She was married and had two children. The husband was the same age and was a steady worker. There were no apparent major marital problems.

From a psychiatric aspect, the patient was of normal intellectual level without evidence of any psychotic process. She had been somewhat depressed for several months. Her complaints included: "Nothing is the same as it used to be! Nobody cares what happens to me, but I know they really do. I feel a mean person at times." It was noted that the patient had a rather special relationship with her father, describing him as a man who "acted as if his kids could do no wrong." Although her father had been dead for 17 years, the patient was quite tearful when describing him.

While the patient felt that her husband was basically "a wonderful father and a wonderful person," she still described some minor dissatisfactions with him. — If he was late coming home from work, she became upset with

him. She felt at times that he showed less interest in her than her father had. She considered he tended to take her for granted.

This patient showed evidence of depression in the sense of minor loss of interest, lack of initiative, and some dissatisfaction with herself in the way she lived. She had evident feelings of inadequacy.

The husband reported that the patient had become a little forgetful, easily tired, and irritable in the preceding six months. He recognized that the patient seemed to sense a lack of closeness with her mother and her siblings and, at his urging, she would phone them several times a month.

Results of a detailed physical review, including laboratory studies and an electroencephalogram, were essentially negative. A Minnesota Multiphasic Personality Inventory was carried out and was considered to be valid. It showed only a slight elevation of the D scale.

The patient related her feelings of "being big, fat, and ugly" as a child. She dated only in her late teens. She continued to have the same feeling even though relatively happily married. She was rather depressed now. It is considered likely that the patient stole various articles of men's clothing to give to her husband so that, in turn, he would pay extra attention to her.

The patient was seen in psychotherapy. The husband was interviewed as well. He showed an understanding of his wife's need for "extra attention" and, in his own way, he had tried to give it. He felt that the patient's act was a symptom of her illness and that he needed to play a part in her recovery. A combination of supportive therapy, with increased understanding on the part of the patient's husband, appeared to bring the situation under control. However, only a five-year follow-up will provide a more accurate evaluation of the result.

A 33-year-old secretary was charged with petty larceny and was referred for evaluation and treatment. She

Dr. Kenyon, Toledo, Attending Staffs, St. Charles and Toledo Hospitals.
Submitted September 3, 1975.

had taken several small items used in sewing, a total value of less than \$10.

The patient's mother had multiple pregnancies, but the patient was the only survivor by her mother's marriage. She slept with her parents until she was 6 years old, and had quite a close relationship with them. In her own words, "I was extremely close to my mother. I never had a baby-sitter in my entire life." She attempted to maintain a close relationship with her mother following her marriage, but her husband indicated his resentment of even frequent telephone calls. Thus, it was not possible to comfortably maintain the mother-daughter relationship.

The patient's general physical health was good; she had a college education, was married, and had two children. She had attempted to maintain a close relationship with her husband, and had identified with his wishes and ambitions as far as possible. In one sense, she gave up her own identity to become what she thought he wished from her. She rebelled on rare occasions but recognized, in her own words, "I am locked in my box," meaning she followed a life pattern expected of her in her immediate situation and seldom rebelled or displayed her own individuality. She felt her husband showed little, if any, understanding of their relationship; yet, in his own way, he was living up to his own expectations of his duty as a husband.

It was during such a period of rebellion, when the patient felt dissatisfied with her existence and unable to establish herself independently, that she "gifted herself" with the items from a store. She was a woman of above-average intellectual endowment, did not have to account for a small amount of money, and had considerable money available to her. The petty larceny she committed was pointless in the sense of economic gain or need.

She was seen several times for psychotherapy. She seemed to show a considerable understanding of her condition, was able to verbalize quite well, but felt there was no way she could change her relationship with her husband.

A 28-year-old professional woman had taken several items, all less than \$10 in value, from a store. The first theft occurred in 1972, the second in 1973, and a \$2 item was taken in early 1975.

The patient's parents were both living. She felt quite close to her father. No family history of overt psychotherapy or epilepsy was elicited. The patient's general health had been good. She finished her professional training after marriage and had been working in her profession for more than five years. She attended church regularly. She was married and had two children. The relationship with her husband had been uncomfortable at times, in the sense that she felt he did not understand her emotional needs. The episodes of theft occurred on two occasions after the husband had shown an interest in someone outside the marriage. The patient felt she was "trapped" in a domestic situation. She had a good deal of unresolved hostility with a sense of frustration. She

was 75 pounds over normal weight during her early years. As a child, she had felt she was "not acceptable," and had dated only rarely. Eventually, she lost the extra weight but never lost her sense of inadequacy. An example of the relationship with her husband was that, at times, he would ask her how her day went but never literally listened to the report she gave him. She felt she never was able to really communicate with her husband. She recognized that his personality make-up was such that he found it extremely difficult to voice his own feelings of frustration or his problems to her. The stealing episodes had occurred on two different occasions when her husband had interests outside the marriage. The third occasion followed several unresolved dissatisfactions about money problems. The husband had spent money on an item that she felt they could ill afford and which was quite unnecessary. The third time she stole occurred shortly after this episode.

This patient was of above-average intelligence; she showed no evidence of a psychotic process. There was no overt evidence of a depressive episode. The patient's Minnesota Multiphasic Personality Inventory revealed no deviations. She was able to express herself quite well and to recognize the pattern of behavior she was following. She showed intellectual insight without significant change. She had a trial with treatment at a local agency, but she never felt enthusiastic about the treatment. Her attempts at psychotherapy involved her own intellectualization of the problem. She never seemed to resolve the situation.

These patients have in common theft for no apparent economic gain and which is not in keeping with their past behavior. They had the money to pay for the articles. While the stealing was sometimes carried out on more than one occasion, each theft was associated with frustration and unhappiness on the patient's part, and appeared to be an unsatisfactory way to relieve their depression and sense of frustration momentarily.

Attempts at psychiatric treatment have not always been successful since the act was repeated years later. The patients' need for emotional gratification may have been beyond that afforded by marriage. The embarrassment, shame, and sense of degradation, which had existed in their childhood, were further reinforced by the act. The emotional penalties the patients paid were very great compared to any penalty the court could administer.

It seems contradictory that the act itself will bring the individual a loss of self-esteem although, at times, this is a significant part of the initial problem. It intensifies the problems in the marriage. It may have one possible advantage to the patient, aside from the compulsive nature of the act, in that it may focus attention on the patient's needs in a way not possible previously. Kleptomania has been regarded as a striving to compensate for the loss of sexual satisfaction in the broad sense of protection, closeness, and enhanced self-esteem.³ Frequently, the stolen properties have symbolic meaning for the patient. On the superficial level, they represent a gift she wished to receive from her husband or one she wished to

give her husband for which he would be obligated to reciprocate with deeper levels of meaning. At times, stealing may represent doing a forbidden thing secretly.

These thefts are a nuisance to the store, to the courts, and to the judicial process.

It is recommended that such individuals' sentence include psychiatric referral, a period of probation for two years, and a request for a psychiatric report at the end of each six-month period. In case of repetition of the offense, a longer period of probation and regular six-month-interval reports should be requested.

To "overlook" the crime is to neglect the patient's cry for help. The act itself indicates the patient's inability to resolve her conflicts, presumably the spouse's inability

to recognize and deal with the patient's emotional needs, hence, a period of probation without publicity is indicated.

With women's liberation and changes in conjugal role playing, kleptomania may be recorded more frequently in men. Currently, it is most common in women.

References

1. Redlich, FC, Freedman DX: *The Theory and Practice of Psychiatry*. New York, Basic Books, 1966, pp 256-268, 383-384, and 795-796.
2. *Ohio Revised Code*, 29:69-72, 324-330, 1975.
3. Benedek TF: Sexual functions in women and their disturbance, in Silvano Arieti, et al (eds): *American Handbook of Psychiatry*, New York, Basic Books, 1959, 727-728.



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Crossing County Lines

Montgomery County Glee Club To Sing at Opening Session Of 1976 House of Delegates

During January, the Montgomery County Medical Society held its Annual Meeting at which time incoming President John Worthman, M.D., received the gavel. Dr. Worthman noted in his address that it is increasingly important the patient feel that his physician cares about him, that he is receiving appropriate medical care, and that he, as a patient, is needed.

Dr. Worthman stated, "Where the physician is sincerely concerned, he communicates it." He continued by indicating that if a physician cannot establish a relationship with patients, he should either choose an area of medicine not requiring patient contact, work on communicating, or get out of medicine.

The meeting was highlighted by the presentation of 50-Year Awards to several Dayton-area physicians. Of special interest were the awards given Ralph W. Cass, M.D., and Charles A. Heuneke, M.D. These men met in medical school and have practiced together for 50 years at the same office location.

W. J. Lewis, M.D., OSMA Second District Councilor, presented the 50-Year Awards and directed the evening's entertainment, a concert by the Montgomery County Medical Society Glee Club. At the time Dr. Lewis organized this group in 1957, it was the only glee club in the world consisting entirely of practicing physicians. The group gave its premiere concert at the Montgomery County Medical Society Inaugural Ball in 1958. In 1961, the physicians sang at the inaugural of the AMA president



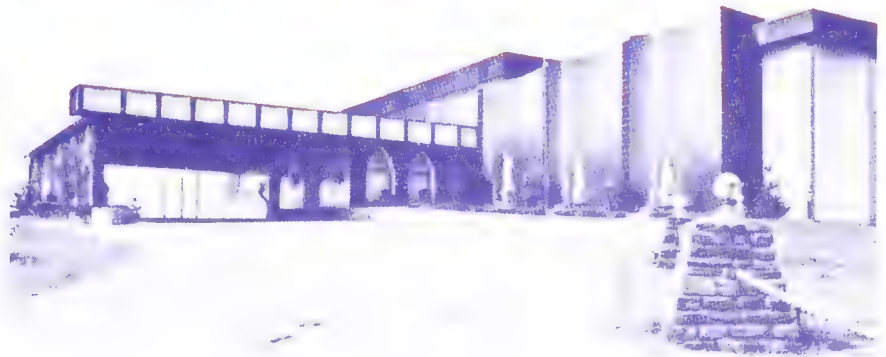
at the Waldorf-Astoria, New York City; and in 1972, they performed at the AMA Clinical Session, Cincinnati.

The MCMS Glee Club will perform at the opening session of 1976 OSMA House of Delegates. They have been invited to join in the Bicentennial Celebration that will mark the opening of "Medical Spirit '76," the Annual Meeting.



TWO OSMA ANNUAL MEETING FEATURES HELD AT CONVENTION HALL AND BEVERLY HILLS COUNTRY CLUB

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Beverly Hills Country Club is the setting for the 1976 OSMA Social Function to be held during the Annual Meeting on **TUESDAY evening, MAY 11.**

Buses will leave Stouffer's Cincinnati Inn at 6:30 PM for the club and will return after an evening of dinner and dancing.

MENU

7-8 PM — Canapes and Hot and
Cold Hors d'oeuvres
Broiled Chicken Livers/Bacon
Swedish Meat Balls
Chicken Liver Molds
Cheese Dips
Fried Miniature Chicken Legs

Cash Bar (one drink will be
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8 PM — **PRIME RIB** dinner
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OMPAC SPEAKER...ROBERT D. NOVAK

The Ohio Medical Political Action Committee (OMPAC) speaker at the Annual Meeting is Robert D. Novak. Mr. Novak, a Washington, D.C., columnist who writes the syndicated column "Inside Report" published in more than 250 newspapers in the United States and abroad, has been the OMPAC speaker in previous years. He will deliver his address at a noon luncheon on Tuesday, May 11.



Mr. Novak and his coauthor Rowland Evans, Jr., give appraisals from behind the scenes of significant and unexpected developments on national, state and local trends as well as cover the international scene. Robert Novak is often described as a news-hungry journalist who specializes in investigation and probing analysis instead of armchair commentary.

A graduate of the University of Illinois, Mr. Novak began his newspaper career in his hometown on the Joliet *Herald News*. After serving as a lieutenant in the Korean War, he joined the Associated Press Omaha office and later continued with the news service in Lincoln, Nebraska, and Indianapolis. In 1957, he went to Washington as Capitol Hill Correspondent for the Associated Press and transferred to *The Wall Street Journal* in 1958 as Senate correspondent and political reporter. Later he became their Chief Congressional Correspondent.

Since 1963, he and Mr. Evans have been writing "Inside Report" and a bi-weekly newsletter, "Evans-Novak Political Report." Mr. Novak also has written *the Agony of the G.O.P.* (1964), and coauthored with Mr. Evans *Lyndon B. Johnson: The Exercise of Power* (1966) and *Nixon in the White House* (1971).

Annual Meeting Pre-Registration and Ticket Form

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OSMA House of Delegates Agenda

SUNDAY, MAY 9

3-7 PM	Registration for OSMA House of Delegates	Upper Lobby, Convention Hall
4 PM	Councilor District Caucus Meetings (Location of Caucus Meetings, which will be held at Stouffers or Terrace Hotels, will be posted at Registration Desk.)	
5:30 PM	Dinner for Delegates, Alternates, OSMA Council and Official Guests	Convention Hall, Room E
6:30 PM	Opening Session: Business Agenda	Convention Hall, Room O
	Call to Order by the President—Maurice F. Lieber, M.D. Canton	
	Invocation—Father John W. Lasca, Gesu Church, Toledo	
	Welcome by Neal N. Earley, M.D., Cincinnati, President, Academy of Medicine of Cincinnati	
	Report of the Committee on Credentials	
	Consideration of the Minutes of the last Annual Meeting (July 1975 issue of <i>The Journal</i>)	
	Introduction of honored guests	
	Report by the President of the Auxiliary—Mrs. Robert E. Krone, Cincinnati	
	Presentation of AMA-ERF checks to representatives of Ohio Medical Schools—Philip B. Hardyman, M.D., Columbus, Chairman, Ohio Committee on AMA-ERF.	
	Presentation of plaques to Past Councilors and retiring AMA Delegates and Alternates, Chairmen and Members of Standing Committees, and Chairmen of Special Committees	
	Presentation of Life Memberships	

Presentation of Distinguished Service Citation

Announcement of appointments by the President to the Reference, Credentials, President's Address, Resolutions, and Tellers and Judges of Election Committees

Election of Committee on Nominations: (Nominations from the floor. One representative [delegate] from each Councilor District. The committee shall report to the second and final session, Wednesday, May 12, 3:30 PM, its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Third District shall serve as Chairman.) The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at the registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

President's Address: Maurice F. Lieber, M.D., Canton

Introduction of Presidents of other State Societies

Introduction of Resolutions (Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House Delegates at the Wednesday afternoon session before any action can be taken.)

Miscellaneous Business

WEDNESDAY, MAY 12

2:30-	Registration for OSMA	Upper Lobby,
3:30 PM	House of Delegates	Convention Hall
3:30 PM	Final Session	Convention Hall, Room O

(continued on page 234)

House of Delegates Agenda

6 PM	Dinner for Delegates, Alternates, OSMA Council, and Official Guests	Convention Hall, Room E
7 PM	Continuation of Final Session of House of Delegates	Convention Hall, Room O
3:30 PM	Final Session Business Agenda	Convention Hall, Room O

Introduction of Guests

Presentation of Art Show Awards

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of Other Officers

(A) Nominations for The Council

Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-

numbered years—**FIRST DISTRICT:** Incumbent, Stephen P. Hogg, M.D., Cincinnati; **THIRD DISTRICT:** Incumbent, John C. Smithson, M.D., Findlay; **FIFTH DISTRICT:** Incumbent, John J. Gaughan, M.D., Cleveland; **SEVENTH DISTRICT:** Incumbent, Robert E. Rinderknecht, M.D., Dover; **NINTH DISTRICT:** Incumbent, Thomas W. Morgan, M.D., Gallipolis; **ELEVENTH DISTRICT:** Incumbent, Robert G. Thomas, M.D., Elyria; **SECRETARY-TREASURER:** Incumbent, William M. Wells, M.D., Newark.

(B) Election of Delegates and Alternates to the American Medical Association

Four Delegates and four Alternates to be elected each for a two-year term starting January 1, 1977, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1976, their terms expiring December 31, 1976.

DELEGATES (Listed alphabetically): Richard L. Meiling, M.D., Columbus; H. William Porterfield, M.D., Columbus; Robert N. Smith, M.D., Toledo; Robert E. Tschantz, M.D., Canton.

ALTERNATES (listed alphabetically): John E. Albers, M.D., Cincinnati; Dwight L. Becker, M.D., Lima; B. Leslie Huffman, Jr., M.D., Maumee; Robert G. Thomas, M.D., Elyria.

All nominees for the offices of AMA Delegates and AMA Alternates shall run at large. Election of Delegates and Alternates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

Reports of Reference Committees

President's Address

Resolutions Committee No. 1

Resolutions Committee No. 2

Resolutions Committee No. 3

Miscellaneous Business

Installation of Officers for 1976-1977

Announcement of Standing Committee Appointments by the newly-installed President and action thereon by the House of Delegates.

Unfinished business

Adjournment

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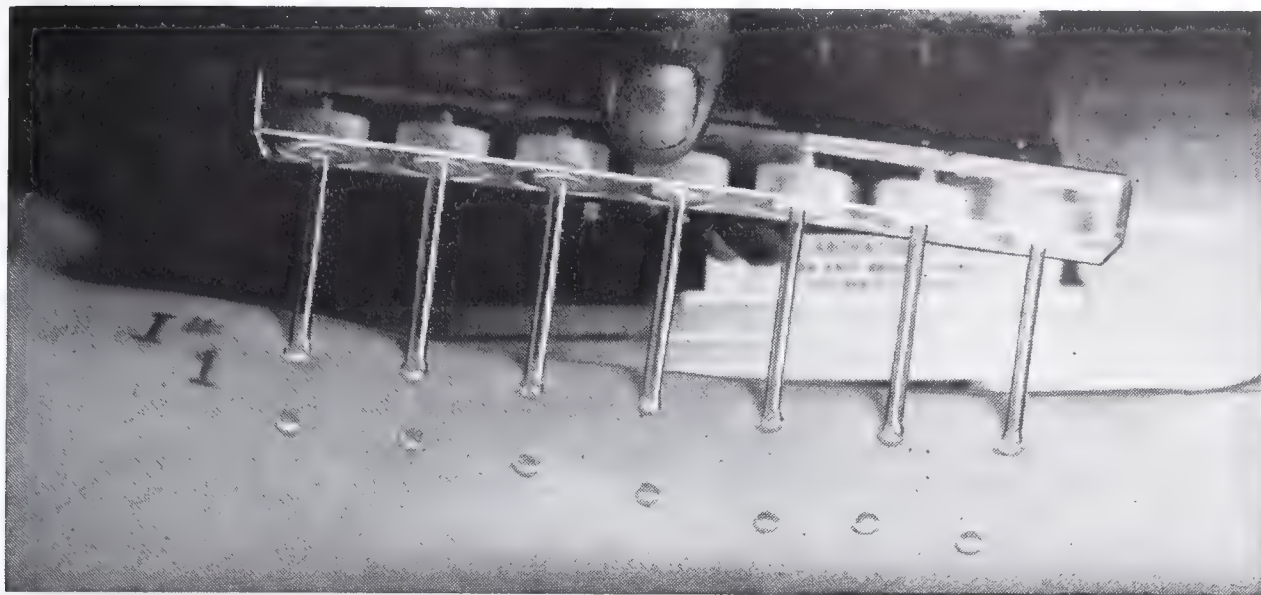
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By county: Delegates left column, Alternate Delegates right column

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BUTLER COUNTY

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James M. Smith, M.D. Marvin Russell, M.D.
James F. Stewart, M.D. James I. Scott, M.D.

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GREENE COUNTY

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MIAMI COUNTY

A. Robert Davies, M.D. Jerry Hammon, M.D.

MONTGOMERY COUNTY

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A. Julian Gabriele, M.D. Wallace E. Johnson, M.D.
W. J. Lewis, M.D. Frederic C. Schnebly, M.D.
John H. Taylor, M.D. John R. Whitaker, Jr., M.D.

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Chester J. Brian, M.D. Everett P. Trittschuh, M.D.

SHELBY COUNTY

George Schroer, M.D.

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HARDIN COUNTY

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LOGAN COUNTY

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Samuel R. Lowery, M.D. Willis L. Damschroder, M.D.

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Robert W. Dilworth, M.D. John E. Moats, M.D.

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Henry A. Crawford, M.D. John E. Coletta, M.D.
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Steven Kovacs, M.D. Gilbert Derian, M.D.
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George P. Leicht, M.D. Hymer L. Friedell, M.D.
Leonard L. Lovshin, M.D. William M. Hegarty, M.D.
Lawrence J. McCormack, M.D. Herman K. Hellerstein, M.D.
Hermann Menges, M.D. Roscoe J. Kennedy, M.D.
Richard J. Nowak, M.D. Robert C. Kirk, M.D.
Thomas P. Paras, M.D. John A. Kmieck, M.D.
George W. Petznick, M.D. Charles K. Koster, M.D.
John G. Poulos, M.D. James Magisano, M.D.
P. John Robeck, M.D. Leroy W. Matthews, M.D.
A. Benedict Schneider, M.D. Valentin F. Mersol, M.D.
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Franklyn J. Simecek, M.D. Joseph Schultz, M.D.
Frederick T. Suppes, M.D. Warner W. Tuckerman, M.D.
Robert J. White, M.D. Howard S. Van Ordstrand, M.D.

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Bruce F. Andreas, M.D. Frederick R. Mautz, M.D.

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John A. Bukovnik, M.D. Harry A. Killian, M.D.
Wesley J. Pignolet, M.D. Joseph H. Myers, M.D.

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William Banfield, M.D. Leonard Pritchard, M.D.

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John Melnick, M.D. Paul J. Mahar, Jr., M.D.
C. Edward Pichette, M.D. William E. Sovik, M.D.
Jack Schreiber, M.D. Joseph W. Tandatnick, M.D.

STARK COUNTY

Edward J. Davis, M.D. John D. Botti, M.D.
Edward E. Grable, M.D. Mark G. Herbst, M.D.
Raymond J. McMahon, Jr., M.D. James J. Thomas, M.D.
William A. White, Jr., M.D.

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COSHOCTON COUNTY

Robert R. Johnson, M.D. Norman L. Wright, M.D.

HARRISON COUNTY

Janis Trupovnieks, M.D. Elias E. Freeman, M.D.

JEFFERSON COUNTY

Irving Dreyer, M.D. Augusto P. Fojas, M.D.

MONROE COUNTY

Donald R. Piatt, M.D.

TUSCARAWAS COUNTY

Philip T. Doughten, M.D. Benjamin J. Wherley, M.D.

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Robert A. Ringer, M.D. Raj Tripathi, M.D.

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MORGAN COUNTY

Austin A. Coulson, M.D. Henry Bachman, M.D.

MUSKINGUM COUNTY

Walter B. Devine, M.D. Carl E. Spragg, M.D.

(continued on page 238)

1976 Delegates & Alternates

NOBLE COUNTY

Edward G. Ditch, M.D.

Frederick M. Cox, M.D.

PERRY COUNTY

Sydney N. Lord, M.D.

Charles McDougal, M.D.

WASHINGTON COUNTY

Gregory Krivchenia, M.D.

Mary Whitacre, M.D.

NINTH DISTRICT

GALLIA COUNTY

Thomas P. Price, Jr., M.D.

Edward J. Berkich, M.D.

HOCKING COUNTY

Lethia Starr, M.D.

Jan S. Matthews, M.D.

JACKSON COUNTY

John W. Zimmerly, M.D.

Carl J. Greever, M.D.

LAWRENCE COUNTY

A. Burton Payne, M.D.

Harry Nenni, M.D.

MEIGS COUNTY

Roger Daniels, M.D.

PIKE COUNTY

Kenneth A. Wilkinson, M.D.

Albert M. Shrader, M.D.

SCIOTO COUNTY

Chester H. Allen, M.D.

Carter L. Pitcher, M.D.

VINTON COUNTY

Not active

TENTH DISTRICT

DELAWARE COUNTY

David R. Smith, Jr., M.D.

Adelbert R. Callander, M.D.

FAYETTE COUNTY

Robert A. Heiny, M.D.

Ralph Gebhart, M.D.

FRANKLIN COUNTY

Homer A. Anderson, M.D.

Ben Arnoff, M.D.

Michael A. Anthony, M.D.

James E. Barnes, M.D.

Robert C. Atkinson, M.D.

William C. Earl, M.D.

Joseph A. Bonta, M.D.

E. Gene Ewy, M.D.

Walter M. Haynes, M.D.

Richard L. Fulton, M.D.

John N. Meagher, M.D.

Frederick M. Kapetansky, M.D.

George W. Paulson, M.D.

William A. Millhon, M.D.

Jack E. Tetirick, M.D.

H. William Porterfield, M.D.

J. Hutchison Williams, M.D.

Philip H. Taylor, M.D.

KNOX COUNTY

James C. McLarnan, M.D.

Henry T. Lapp, M.D.

MADISON COUNTY

Sol Maggied, M.D.

J. Richard Hurt, M.D.

MORROW COUNTY

David J. Hickson, M.D.

William S. Deffinger, M.D.

PICKAWAY COUNTY

Robert G. Smith, M.D.

Ray Carroll, M.D.

ROSS COUNTY

J. S. McKell, M.D.

Lewis Coppel, M.D.

UNION COUNTY

Lawrence Gould, M.D.

Walter Burt, M.D.

ELEVENTH DISTRICT

ASHLAND COUNTY

Jon Cooperrider, M.D.

Charles H. Warne, M.D.

ERIE COUNTY

S. Baird Pfahl, Jr., M.D.

Richard H. Williamson, M.D.

HOLMES COUNTY

Luther W. High, M.D.

Maurice Mullet, M.D.

HURON COUNTY

Nino M. Camardese, M.D.

Earl R. McLoney, M.D.

LORAIN COUNTY

Charles G. Adams, M.D.

Henry E. Kleinhenz, M.D.

Delbert L. Fischer, M.D.

Andrew M. Mattey, M.D.

Thomas Sfiligoj, M.D.

Ray de la Pena, M.D.

MEDINA COUNTY

Richard W. Avery, M.D.

Rolland L. Mansell, M.D.

RICHLAND COUNTY

James F. Clements, M.D.

Donald E. Mills, M.D.

Harold F. Mills, M.D.

James W. Wiggin, M.D.

WAYNE COUNTY

A. Burney Huff, M.D.

John M. Robinson, M.D.

TWELFTH DISTRICT

PORTAGE COUNTY

F. Michael Sheehan, M.D.

John Fulton, M.D.

SUMMIT COUNTY

Roy E. Bugay, M.D.

Rocco Antenucci, M.D.

Robert R. Clark, M.D.

Douglas M. Evans, M.D.

Warren P. Kilway, M.D.

Joseph L. Kloss, M.D.

Emmett P. Monroe, M.D.

Fred F. Somma, M.D.

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Fourth District C. Douglass Ford, M.D.

Fifth District John J. Gaughan, M.D.

Sixth District C. Edward Pichette, M.D.

Seventh District Robert E. Rinderknecht, M.D.

Eighth District Richard E. Hartle, M.D.

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Price Range_____

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No. of
Persons_____

Arrival
Date_____

Hour of
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Departure
Date_____

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MEDICAL ASSOCIATION, MAY 10, 11 & 12 CINCINNATI, OHIO

FRIDAY PROGRAM

The Early Diagnosis & Treatment of Carcinoma of the Breast

WILLIAM E. DONEGAN, M.D., Medical College of Wisconsin
H. STEPHEN GALLAGER, M.D., University of Texas at Houston
MYRON MOSKOWITZ, M.D., University of Cincinnati
JAMES P. FIDLER, M.D., University of Cincinnati

Resident Essay Contest — Winning Papers

Ohio Oration: *"Upper Gastrointestinal Hemorrhage — 1976 Perspective"*

ALEXANDER J. WALT, M.D., Professor & Chairman, Department of Surgery,
Wayne State University

Cine Clinic — How I Do

CHARLES A. HUBAY, M.D. — Parathyroid Adenoma
WILLIAM E. EVANS, M.D. — Aortic Aneurysm
WILLIAM S. BLAKEMORE, M.D. — Techniques of Coronary Artery Surgery
WILLIAM A. ALTEMEIER, M.D. — Right Colectomy with Closed Anastomosis

SATURDAY MORNING

JOHN W. POMPELLI, Department of Organization, American College of Surgeons
"Malpractice — A Continuing Crisis"

Common Problems in Thoracic Trauma

J. KENT TRINKLE, M.D., University of Texas
JAMES W. KILMAN, M.D., Ohio State University
ALEXANDER J. WALT, M.D., Wayne State University

Management of Gastrointestinal Tract Failure

GEORGE L. BLACKBURN, M.D., Harvard Surgical Service
BRUCE G. MACMILLAN, M.D., University of Cincinnati
LESTER W. MARTIN, M.D., University of Cincinnati

Section on Orthopedics — Section on Obstetrics & Gynecology

Resolutions Submitted for Consideration At the 1976 OSMA Annual Meeting

RESOLUTION NO. 1-76

Parliamentarian

(By Academy of Medicine of Toledo)

WHEREAS, The business of the House of Delegates of the Ohio State Medical Association should proceed with dispatch; and

WHEREAS, The last several annual sessions of the House of Delegates have been characterized by confusion and uncertainty; and

WHEREAS, Strict interpretation of the Rules of Order would prevent such misunderstanding; and

WHEREAS, The attorney for the Ohio State Medical Association does not purport to be a parliamentarian; THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association secure and supply an accomplished and competent parliamentarian to ensure orderly procedure for each session of the House of Delegates.

RESOLUTION NO. 2-76

Citizenship Requirements

(By Lorain County Medical Society)

WHEREAS, the Constitution and Bylaws of Lorain County Medical Society, as a component medical society holding a Charter from Ohio State Medical Association, basically follows the concepts contained in the Constitution and Bylaws of the Ohio State Medical Association; and

WHEREAS, The Constitution and Bylaws of Ohio State Medical Association currently requires that an applicant for membership must be a citizen of the United States of America or must have resided in the United States for at least 1 year and declared his intention of becoming a citizen of the United States; and

WHEREAS, The Immigration Authorities no longer require that filing a Declaration of Intention in an appropriate court of record be mandatory; and

WHEREAS, The State of Ohio Medical Board has granted a License to Practice Medicine to aliens holding a Permanent Visa Status or Third Preference Petition Status (which signifies that their applications for Permanent Resident Status are in process); and

WHEREAS, Quota restrictions impose long waiting pe-

riods for some aliens before they can qualify for, or obtain "Permanent Resident" status; and

WHEREAS, No alien is eligible to file a Declaration of Intention to become a citizen of the United States until he has obtained permanent resident status; and

WHEREAS, The Immigration Authorities require that an alien must have Permanent Visa status for a period of 5 years before he becomes eligible for Citizenship; and

WHEREAS, These circumstances prohibit some aliens from complying with Membership Eligibility requirements as outlined in our Constitution and Bylaws,

LORAIN COUNTY MEDICAL SOCIETY is of the opinion that the Constitution and Bylaws should be brought into harmony with facts, and amended to read as follows:

CONSTITUTION ARTICLE III, PARA: 1.

"Any physician who is a citizen of the United States or who has resided in the United States for at least 1 year and who holds a License to Practice Medicine from the State of Ohio Medical Board, who is of good moral and professional standing, who does not support or practice, or claim to support or practice, any exclusive system of medicine, and who meets the membership qualifications prescribed in Chapter I of the Bylaws of this Society, shall be eligible for membership in this Society.

RESOLUTION NO. 3-76

Adding Faculty to Membership Category

(By The OSMA Council)

RESOLVED, That Chapter 1, Section 3, line 2 be amended to provide as follows: "after 'honorary' insert 'faculty'"; and

RESOLVED, That Chapter 1, Section 3(b) of the Bylaws be amended to provide as follows:

"(b) He must hold a limited, temporary, or unlimited certificate to practice medicine and surgery, or osteopathic medicine and surgery, issued by the licensing authority of the State of Ohio, which license must be in full force and effect at the time of his application for membership in this Association, or he must hold an unlimited and unrestricted license or certificate to practice medicine and surgery in any state of the United States of America, or he must be a full-time faculty member holding a degree of doctor of medicine or doctor of osteopathic

(continued on page 242)

1976 Resolutions *(continued)*

medicine and surgery at an accredited college of medicine or an accredited college of osteopathic medicine and surgery."

RESOLUTION NO. 4-76

Advertising

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 5-76

Regulation of Emergency Ambulance Services

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 6-76

Protection Against Frivolous Lawsuits

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 7-76

Confidentiality

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 8-76

Provider-Owned Insurance Company

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 9-76

Retired Physician Exempt from Stabilization Reserve Fund

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 10-76

Automatic Issuance of Reporting Endorsement of JUA

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 11-76

OSMA-Sponsored Courses in English and Basic Sciences for Foreign Medical Graduates

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 12-76

Financing Countersuits

(By Trumbull County Medical Society)

RESOLUTION NO. 13-76

"Assignment" Opposed

(By Lake County Medical Society)

RESOLUTION NO. 14-76

Smoking Ban in Hospitals

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 15-76

OSMA Position on Public Law 93-641

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 16-76

Official Representative of Organized Medicine

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 17-76

Policyholder Consent to Settlements

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 18-76

JUA to Offer Occurrence Contracts

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 19-76

Clarification of Statute of Limitations

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 20-76

Impartial Arbitration

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 21-76

Development of Professional Liability Data

(By Academy of Medicine of Cleveland)

RESOLUTION NO. 22-76

Absent Delegates

(By Thomas F. Moriarty, M.D., Member
Henry County Medical Society)

WHEREAS, During the session of the House of Delegates of the Ohio State Medical Association, the delegation from each councilor district consists of one or more Delegates or one or more Alternate Delegates from each component society within that district as delineated by the Constitution and Bylaws of the Ohio State Medical Association; and

WHEREAS, There are, from time to time, instances when a given component society has neither a full complement of Delegates nor of Alternate Delegates present at a given meeting of the House of Delegates; thus disenfranchising that component society, as well as reducing the voting power of that district; THEREFORE, BE IT

RESOLVED, That when a component society is not fully represented by its Delegates, or Alternate Delegates, or a member in attendance qualified to be designated as a Delegate by the President or Secretary of that unrepresented component society, an Alternate Delegate duly registered by another component society within the same councilor district then can be designated by the councilor of that district as having the authority to cast a valid ballot for the absent Delegate, as matters come before the House of Delegates for a vote during the course of that given session; and BE IT FURTHER

RESOLVED, That should the absent Delegate or an Alternate Delegate from the unrepresented compo-

ment society appear at that given session, while in progress, and make his or her presence known to the councilor of that district, that Delegate or Alternate Delegate shall automatically recover the right to cast a valid ballot for his component society at that session and, the councilor-appointed substitute Delegate would no longer have the right to cast a ballot at that session so long as the component society's designated Delegate remains in attendance; and BE IT FURTHER

RESOLVED, That, should the duly registered Delegate from a component society leave during the course of the session of the House of Delegates and, on leaving, notify the councilor of his or her district that he or she does not intend to return to the session to exercise the right to vote for his or her component society, the councilor of that district then can designate an Alternate Delegate from that component society as having the right to cast a valid ballot for his or her component society; or, in the absence of a duly registered Alternate Delegate from that component society, the councilor then can designate a duly registered Alternate Delegate from another component society within the same district as having the right to cast a valid ballot for the unrepresented component society, as matters come before the House for vote at that given session; and BE IT FURTHER

RESOLVED, That the councilor of each district be required to maintain a written record of the names of the Alternate Delegates and of the component societies involved in such substitutions which he or she has authorized during the course of the session of the House of Delegates, should such substitutions occur; and that these records be submitted to the office of the Executive Director of the Ohio State Medical Association for safe keeping following the course of each session so that they will be available should a challenge arise concerning the validity of ballots so cast; and BE IT FURTHER

RESOLVED, That the Constitution and Bylaws of the Ohio State Medical Association be appropriately changed so that such councilor designations can be performed legally during or before any and all sessions of the House of Delegates of the Ohio State Medical Association beginning with the 1977 Annual Meeting.

RESOLUTION NO. 23-76
Hospital Discharge Data Acquisition
(By Huron County Medical Society)

RESOLUTION NO. 24-76
Direct Billing
(By Huron County Medical Society)

(continued on page 244)



ABOVE: OSMA President Maurice L. Lieber and family at the 1975 Annual Meeting. **BELOW:** George N. Bates, M.D., OSMA President-Elect; Jack E. Tetirick, M.D.; and Oscar W. Clarke, M.D.

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1976 Resolutions *(continued)*

RESOLUTION NO. 25-76

P.S.R.O.

(By Huron County Medical Society)

RESOLUTION NO. 26-76

National Health Insurance

(By Huron County Medical Society)

RESOLUTION NO. 27-76

The Patient Speaks

(By Huron County Medical Society)

RESOLUTION NO. 28-76

Free Enterprise Coalition Citizens-Physicians-Hospital Administrators-Boards of Trustees

(By Huron County Medical Society)

RESOLUTION NO. 29-76

Amendment of House Bill 682

(Academy of Medicine of Cincinnati)

RESOLUTION NO. 30-76

Medical Liability Insurance Premiums Related to Exposure

(Academy of Medicine of Cincinnati)

RESOLUTION NO. 31-76

Disclosure of Professional Liability Statistics

(Academy of Medicine of Cincinnati)

RESOLUTION NO. 32-76

Commendation for Richard Meiling, M.D.

(Academy of Medicine of Cincinnati)

RESOLUTION NO. 33-76

Establishment of Culture Committee

(Academy of Medicine of Cincinnati)

RESOLUTION NO. 34-76

Physicians Registration

(Academy of Medicine of Cincinnati)

RESOLUTION NO. 35-76

Citizenship Requirements

(Council of the Academy of Medicine of Columbus and Franklin County)

WHEREAS, Section 3 and Section 6 of Chapter I (Membership) of the Bylaws of the Ohio State Medical Association state that, to be eligible for membership in OSMA, a *non-citizen* must—

- 1) live in the United States for a period of one year;
- 2) file in an appropriate court of record a declaration of intent to become a citizen;

- 3) wait three years after filing his declaration of intent before he can apply for membership in a component society;
- 4) exercise his intent to become a citizen within six years after filing his declaration of intent else his membership in the component society will be cancelled; and

WHEREAS, The Ohio State Medical Board will now issue a license to an applicant if *one* of the following is submitted:

- 1) proof of citizenship;
- 2) declaration of intent (official document of the court);
- 3) alien registration receipt record (official document-U.S. Immigration Service);
- 4) petition for Permanent Immigration Status (official document-U.S. Immigration Service); and

WHEREAS, Membership eligibility for the OSMA and the component county medical societies exceeds licensure requirements of the Ohio State Medical Board and thereby grants membership on citizenship status arbitrarily;

WHEREAS, It is desirable for all licensed physicians in Ohio to be eligible for membership to the OSMA and the component county medical societies; THEREFORE, BE IT

RESOLVED, That the OSMA Bylaws be amended as follows: Chapter 1 Section 3; Delete paragraph (2) [Paragraph (b) then becomes (a) and paragraph (c) becomes (b)]. Delete Section 6, (Section 7 becomes 6 and 8 becomes 7).

RESOLUTION NO. 36-76

Abortion

(By N. M. Camardese, M.D., Delegate, Huron County Medical Society)

RESOLUTION NO. 37-76

Congratulations to AMA

(By Ross County Medical Society)

RESOLUTION NO. 38-76

Failure of PSRO

(By Ross County Medical Society)

RESOLUTION NO. 39-76

Inform the Public About Professional Liability

(Academy of Medicine of Cleveland)

RESOLUTION NO. 40-76

Determination of Death

(Academy of Medicine of Cleveland)

RESOLUTION NO. 41-76
Licensing of Physician's Assistants
(Academy of Medicine of Cleveland)

RESOLUTION NO. 42-76
Maximum Allowable Cost Regulations
(By The OSMA Council)

RESOLUTION NO. 43-76
Redistricting the Ohio State Medical Association
(By Holmes County Medical Society)

RESOLUTION NO. 44-76
Malpractice Lawsuits
(By Fourth Councilor District)

RESOLUTION NO. 45-76
Special Assessment for Proposed Countersuits
(By Second Councilor District)

RESOLUTION NO. 46-76
Persecution of Religious Minorities
(By Second Councilor District)

RESOLUTION NO. 47-76
Nomination and Election of District Councilors
(Implementation Resolution 37-75)

RESOLVED, That Chapter 5 of the Bylaws of the Ohio State Medical Association be amended by the addition of the following section, which shall be Section 4 of Chapter 5.

Section 4. Nomination and Election of District Councilors. Nominations for the office of district councilor shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided; that the name of a candidate for the office of councilor must be filed by the caucus of that district's delegates with the Executive Director of the Association prior to the opening of the first session of the House of Delegates in Annual Meeting, and that no nomination for councilor may be presented at any meeting unless the foregoing has been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds ($\frac{2}{3}$ rds) of the delegates present at the opening session of such meeting, and **BE IT FURTHER**

RESOLVED, That the present Chapter 5, Section 4 be re-numbered Chapter 5, Section 5; that Section 5, be re-numbered Section 6; Section 6 be Section 7, and Section 7 be re-numbered Section 8.

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1976 OSMA Annual Meeting Program

SATURDAY, MAY 8

4 PM	Ohio Psychiatric Assn. Foundation Meeting	Stouffers, Cabana A Room
5 PM	Ohio Psychiatric Assn. Council Meeting	Stouffers, Bamboo A Room
6:30 PM	Ohio Psychiatric Assn. Council Dinner	Stouffers, Bamboo A Room
8 PM	Ohio Psychiatric Assn. Council Meeting (contd.)	Stouffers, Bamboo B Room

SUNDAY, MAY 9

9 AM-2 PM	Ohio Psychiatric Assn.	Emerson North Hospital
3-7 PM	Registration for OSMA House of Delegates	Upper Lobby, Convention Hall
4 PM	Councilor District Caucus Meetings (Rooms will be posted at registration desk.)	
5:30 PM	Complimentary Dinner for Delegates, Alternates, OSMA Council and Official Guests	Room E, Convention Hall
6:30 PM	Opening Session of the Annual Meeting. (All members and guests welcome to attend.)	Convention Hall Room O
9 PM	Reception for everyone. Cash Bar	Stouffers, Bronze Rooms A and B

MONDAY, MAY 10

8:30 AM-12 Noon	Reference Committee Hearings	Convention Hall
	Res. Comm. No. 1	Room P
	Res. Comm. No. 2	Room R
	Res. Comm. No. 3	Room T
	President's Address	Room V
	Nominations Committee	Room W
8:30 AM	General and Advance Registration Opens	Convention Hall Exhibit Floor
9 AM-12 Noon	Section on Otolaryngology	Convention Hall, Room C
10:30 AM-12:15 PM	Section on Directors of Medical Education	Convention Hall, Room A
11 AM	Opening Session, Ohio Health Commissioners	Convention Hall, Room L

11:30 AM	Luncheon, Section on Neurology	Stouffers, Ivory A
12 Noon	All Exhibits Open Art Show Opens	Convention Hall Convention Hall, Exhibit Floor
12 Noon-1:30 PM	Tour of Exhibits	
1-3 PM	Section on Dermatology	Convention Hall, Rooms M & N
1-3:30 PM	Rape: Victim and Offender	Convention Hall, Room E
1:30 PM	Reference Committee Hearings (contd. if necessary)	Convention Hall,
	Res. Comm. No. 1	Room P
	Res. Comm. No. 2	Room R
	Res. Comm. No. 3	Room T
	President's Address	Room V
	Nominations Committee	Room W
1:30-5 PM	Section on Neurology	Convention Hall, Room B
3:30-4:30 PM	Free Beer	Convention Hall, Exhibit Floor
4:30 PM	Close Exhibits and Art Show for Monday	
5-6 PM	Reception for Exhibitors	Stouffers, Bamboo A & B
5-6:30 PM	OMI Reception	Stouffers, Commodore Room
8-10 PM	Medical Mutual of Cleveland Hospitality Suite	Stouffers, Bamboo A & B

TUESDAY, MAY 11

7:30-9 AM	CME Courses (Courses continued on Wednesday at the same time.)	Convention Hall
\$15.00 per course		
	Course 1 — Clinical Management of Electrolyte and Acid Base Disturbances	Room M-2
	Course 2 — Principles of Electrocardiology	Room N-2
	Course 3 — Chemotherapy of Infections	Room N-1
	Course 4 — Diagnosis and Plan of Management of Common Vascular Problems	Room M-1

Course 5 — Noninvasive Diagnosis of Cardiovascular Disease Room S

Course 6 — Sexual Counseling. Room P

Course 7 — Business Management in the Doctor's Office Room R

Course 8 — Chronic Obstructive Pulmonary Diseases Room T

Course 9 — Office Management of Headaches Room U

8 AM Assn. of County Medical Executives Breakfast Stouffers, Bamboo A

8 AM-12 Noon Ohio State Neurosurgical Society Convention Hall, Room G (all day)

8:30 AM General and Advance Registration Opens

9 AM All Exhibits Open
Art Shows Open
Ohio Health Commissioners Institute Convention Hall, Room L

9-11:30 AM Section on Otolaryngology Convention Hall, Room H
Section on Internal Medicine Convention Hall, Room A

9 AM-12 Noon Section on Emergency Medicine and Ohio Comm. on Trauma, A.C.S. Convention Hall, Room B

Basic Life Support Course I (CPR) (This starts at 9 AM and is a three-hour course.) Convention Hall, Exhibit Floor

Please register in advance. (no charge)
Section on Pathology and Ohio Soc. of Pathologists Convention Hall, Room F (all day)

11:30 AM Luncheon, Section on Physical Medicine and Rehabilitation and Ohio Soc. of Physical Med. and Rehabilitation Stouffers, Ivory A

11:30 AM OMPAC Luncheon and Speaker, Robert D. Novak (purchase tickets, \$8.00 per person) Convention Hall Rooms E, C. & D

12 Noon Luncheon, Section on Otolaryngology Stouffers, Commodore Room

12 Noon-12:15 PM Business Meeting, Section on Emergency Medicine Convention Hall, Room B

12:30 PM Luncheon, Section on Emergency Medicine and Ohio Comm. on Trauma, A.C.S. Stouffers, Ivory B

12 Noon-1:15 PM Luncheon, Section on Rheumatology and Ohio Rheumatism Society Stouffers, Bamboo B

(continued on page 248)

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Annual Meeting Program *(continued)*

1 PM	Luncheon, Ohio State Neurosurgical Society	Banker's Club
1:30 PM	Section on Sports Medicine	Convention Hall, Room P
1:30-2 PM	Tour of Exhibits and Art Show	
1:30-4:30 PM	Section on Otolaryngology	Convention Hall, Room H
1:30-5 PM	Section on Rheumatology and Ohio Rheumatism Soc.	Convention Hall, Room M-1
	Section on Physical Medicine and Rehabilitation and Ohio Soc. of Physical Medicine and Rehabilitation	Convention Hall, Room N-1
2-4 PM	Section on General Practice and Ohio Academy of Fam. Physicians	Convention Hall, Room D
2-5 PM	Section on Anesthesiology	Convention Hall, Room J

2-6 PM	Ohio State Neurosurgical Society	Convention Hall, Room G (all day)
3:30-4:30 PM	Free Beer	
4:30 PM	Close Exhibits and Art Show for Tuesday	
6:30 PM	OSMA Social Function	Beverly Hills Country Club
Buses Leave Stouffers	Dinner-Dance (Purchase Tickets)	

WEDNESDAY, MAY 12

7:30-9 AM	CME Courses (Courses contd. from Tuesday morning program) Course 1—Clinical Management of Electrolyte and Acid Base Disturbances	Convention Hall
	Course 2—Principles of Electro-Cardiology	Room M-2
	Course 3—Chemotherapy of Infections	Room N-2
	Course 4—Diagnosis and Plan of Management of Common Vascular Problems	Room N-1
	Course 5—Noninvasive Diagnosis of Cardiovascular Disease	Room M-1
	Course 6—Sexual Counseling	Room S
	Course 7—Business Management in the Doctor's Office	Room P
	Course 8—Chronic Obstructive Pulmonary Diseases	Room R
	Course 9—Office Management of Headaches	Room T
		Room U
8-9:30 AM	Breakfast, Board of Governors, Ohio Ophthalmological Society	Stouffers, Ivory A
8:30 AM	General and Advance Registration Opens	
9 AM	All Exhibits Open Art Show Opens Ohio Health Commissioners Institute	Convention Hall, Room L Room L




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9 AM-12 Noon	Section on Plastic Surgery Basic Life Support Course I (CPR). Please register in advance. (No charge) This is a three-hour course.	Convention Hall, Room A Convention Hall, Exhibit Floor
9:30 AM-12:30 PM	Program and Business Meeting, Section on Ophthalmology	Convention Hall, Room C
10-10:30 AM	Tour of Exhibits	
11:45 AM-1:00 PM	Luncheon and Business Meeting, Section on Colon and Rectal Surgery	Stouffers, Ivory A
12 Noon	Luncheon, Committee on Scientific Work Luncheon, Section on Allergy and Ohio Soc. of Allergy and Immunology Luncheon, Section on Plastic Surgery	Stouffers, Bamboo B
1-3 PM	Luncheon and Business meeting, Ohio Ophthalmological Society	Stouffers, Ivory B
1:30 PM	Ohio Health Commissioners	Convention Hall, Room L
1:30-3:30 PM	Ohio Society for the Prevention of Blindness Program	Convention Hall, Room C
1:30-4:30 PM	Section on Allergy and Ohio Society of Allergy and Immunology Section on Colon and Rectal Surgery	Convention Hall, Room B Convention Hall, Room D
2:30 PM	Registration for Final Session for the House of Delegates	Upper Lobby, Convention Hall
3 PM	Dismantle all Exhibits	
3:30 PM	Final Business Session of the House of Delegates	Convention Hall, Room O
6 PM	Complimentary Dinner for Delegates, Alternates, OSMA Council, and Guests	Convention Hall, Room E
6:45 PM	Continuation of Final Session	Convention Hall,

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Program Entitled "Rape: Victim and Offender" Highlight of Annual Meeting

One of the highlights of the Annual Meeting is the program on "Rape: Victim and Offender" scheduled for Monday, May 10, at 1 PM in the Cincinnati Exposition Center. Participants in this program are A. Nicholas Groth, Ph.D., and Ann Wolbert Burgess, R.N., D.N.Sc., both of Massachusetts.

The discussants will cover the mythological aspects of rape which are countered by clinical research, patterns of rape, diagnosis of the aggressive sexual offender, counseling implications for the rape victim, and treatment of the aggressive sexual offender.

For the past ten years, Dr. Groth, a graduate of Boston University, has been involved in the diagnostic assessment and treatment of convicted rapists and child offenders as Chief Psychologist at the Massachusetts Treatment Center for Sexually Dangerous Persons. He is consultant to the Massachusetts Criminal Justice Training Council and holds teaching appointments at Northeastern University and Simmons College in Boston.

Dr. Burgess is a nurse-psychotherapist and researcher in crisis intervention and victimology at Boston College. Her research with rape victims was carried out while she was a victim counselor at the Boston City Hospital Emergency Floor.

Scientific Offerings Abundant at Annual Meeting

SUNDAY, MAY 9

8:30 AM Registration

9 AM Welcoming Remarks: Charles D. Feuss, M.D., Medical Director, Emerson A. North Hospital; Jaime Smith e Incas, M.D., President, Ohio Psychiatric Association; Richard Dorsey, M.D., Program Chairman, Ohio Psychiatric Association.

9:15 AM Clinical Applications of Biofeedback: Bernard Engel, Ph.D., Laboratory of Behavioral Sciences, National Institute of Child Health and Human Development, Baltimore, Maryland.

10 AM Psychotherapy in Psychosomatic Disorders: Robert Kelner, M.D., Ph.D., Professor of Psychiatry, University of New Mexico, Albuquerque, New Mexico.

10:30 AM Break

10:45 AM Behavior Modification in Psychosomatic Disorders: Stewart Agras, M.D., Professor of Psychiatry, Stanford University, Palo Alto, California.

11:45 AM Transcendental Meditation in Psychosomatic Disorders: Harold Bloomfield, M.D., Institute for Psychophysiological Medicine, San Diego, California.

12:30 PM Panel Discussion: Moderator: Barry Blackwell, M.D., Professor and Chairman, Department of Psychiatry, Wright State University, Dayton, Ohio.

1 PM Lunch and Business Meeting

2 PM Adjourn (leave for airport)

MONDAY, MAY 10

Dermatology for the Primary Care Physician Clinic

A new concept, for the Annual Meeting, in physician education shall be presented by the OSMA Section on Dermatology. Patients with the following dermatoses shall be seen: eczema, acne, psoriasis, pigmentary dermatoses, contact dermatitis, birthmarks, and skin malignancies. After viewing the subjects in separated areas, a one-hour discussion of each case, by a panel of dermatologists, shall follow. The following dermatologists will participate on the panel:

Moderator: Z. Charles Fixler, M.D., Associate Clinical Professor of Dermatology, University of Cincinnati, Attending Physician, Veterans Administration Hospital, Cincinnati, and Program Chairman, Section on Dermatology.

Panelists: William Dorner, Jr., M.D., Akron,

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MONDAY, MAY 10

Continuing Medical Education . . . Present and Future

The following program is sponsored by the OSMA Section on Directors of Medical Education:

Moderator: Donald J. Vincent, M.D., Director of Medical Education, Riverside Methodist Hospital, Columbus; and Chairman, OSMA Section on Directors of Medical Education.

10:30-11 AM Robert L. Tupper, M.D., Director of Medical Education, Blodgett Memorial Hospital, Grand Rapids, Michigan

11 AM-12 Noon Panel Program

Participants: Robert L. Tupper, M.D., Grand Rapids, Michigan; Howard S. Madigan, M.D., Associate Dean, Continuing Education, Medical Col-

lege of Ohio at Toledo; Stanley W. Olson, M.D., Provost, Northeastern Ohio Universities, Kent; and John G. Sholl, M.D., Cleveland, Chairman, OSMA Commission on Medical Education.

TUESDAY, MAY 11

Symposium on Cardiovascular Emergencies

This symposium is sponsored by the OSMA Section on Emergency Medicine and the Ohio Committee on Trauma, A.C.S.

Moderator: Robert C. Waltz, M.D., Cleveland, President and Program Chairman, Ohio Committee on Trauma, A.C.S.

9 AM "Hypotension! Is He Bleeding?" — Robert M. Zollinger, Jr., M.D., Cleveland, Secretary, Ohio Committee on Trauma, A.C.S.

9:20 AM "What, No Whole Blood?" — J. Wesley Alexander, M.D., Professor of Surgery, University of Cincinnati Medical Center.

9:40 AM "A New Way to Skin the Cat (EMI Scanner) in Acute Emergencies" Robert R. Lukin, M.D., Assistant Professor of Radiology and Director of Neuroradiology, University of Cincinnati Medical Center.

10 AM Discussion. Moderator: Francis A. Greicius, M.D., Rocky River, Chairman, Section on Emergency Medicine. *(continued on page 252)*

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Scientific Offerings (continued)

- 10:15 AM Break
10:30 AM "Hemorrhagic Shock — Diagnosis and Treatment" — Robert P. Hummel, M.D., Associate Professor of Surgery and Director of the Burn and Trauma Unit, University of Cincinnati Medical Center.
10:50 AM "Modern Monitoring of Cardiovascular Emergencies" — Dennis Nicholson, M.D., Director of Surgical Intensive Care Unit, University Hospitals, Cleveland.
11:30 AM Discussion
11:45 AM-12:30 PM A Traumatic Free-For-All on Cardiovascular Emergencies. Moderator: Robert M. Zollinger, Jr., M.D.
12:30 PM Luncheon and Business Meeting

TUESDAY, MAY 11

The following is the revised program sponsored by the OSMA Section on General Practice and the Ohio Academy of Family Physicians.

Moderator: Edward H. Miller, M.D., Acting Director, Department of Orthopedic Surgery, University of Cincinnati Medical Center.

- 2-2:45 PM Business Meeting
2:45-3 PM "The Common Foot Problems Including Shoe Corrections for Adults and Children" — Nicholas J. Giannestras, M.D., Department of

Orthopedics, University of Cincinnati Medical Center.

- 3-3:10 PM "Sprains and Strains with Particular Relationship to the Knee and Ankle" — Frank Noyes, M.D., Department of Orthopedics, University of Cincinnati Medical Center.

- 3:15-4 PM Question and Answer Period and Practical Demonstrations

TUESDAY, MAY 11

The program sponsored by the OSMA Section on Sports Medicine will be dealing with different areas of athletics. It is acceptable for 2½ hours credit by the American Academy of Family Physicians.

- 1:30 PM Welcome — Harold Meyer, Ph.D., Columbus, Commissioner, Ohio High School Athletic Association.
1:40 PM "Baseball Elbow" — Richard F. Slager, M.D., Columbus Orthopedic Surgeon and Member, OSMA Committee on Sports Medicine.
2 PM "The Blossoming Role of the High School Athletic Trainer" — Mr. William Taylor, Trainer, Taft High School, Hamilton; and Mr. John Ross, Trainer, Garfield High School, Hamilton.
2:20 PM "Bicycling for Your Health" — Gene Wright, M.D., Chief of Staff, Lima Memorial Hospital and Member, OSMA Committee on Sports Medicine.
2:40 PM Break
3 PM "Equipment Modifications — Its Relation to Football Injuries" — Merrill A. Ritter, M.D., Team

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3:30 PM "Personality Traits and Athletic Injuries" — Everett L. Jung, M.D., Team Physician, Miami University, Oxford.

3:50 PM "A Lay Panel Surveys a Community Athletic Problem" — Mr. James Blout, Executive Editor *Hamilton Journal News*, Hamilton.

4:10 PM "The Female Athlete — A Reality" — Mary Wolverton, Ph.D., Professor of Physical Education, University of Cincinnati.

4:30 PM Panel of all participants.

WEDNESDAY, MAY 12

The program sponsored by the OSMA Section on Colon and Rectal Surgery will be an afternoon of time well spent. Roscoe Earl Miller, M.D. of Indianapolis, Indiana, will be the out-of-state guest speaker. The Course Director is A. Gerson Carmel, M.D., Fairfield, Program Chairman, Section on Colon and Rectal Surgery.

See page 185 of the March 1976 issue of *The Journal* for details.

TUESDAY, MAY 11, AND WEDNESDAY, MAY 12

Cardiopulmonary Resuscitation (Basic Life Support)

Fee: NO CHARGE (Must Preregister)

Instructors and equipment supplied by The American Heart Association Southwestern Ohio Chapter.

Course Directors: Mark M. Popil, M.D., Director, Emergency Services, Good Samaritan Hospital, Cincinnati; and Gary Miller, Chairman of the Committee on Emergency Cardiac Care-Heart Association.

Location: Exhibit Floor, Cincinnati Exposition Center

Course will involve training according to the National Standards of Basic Life Support (CPR) as published in the supplement of the *JAMA*, February 1974. Class participants will be taught and certified in performance skills of cardiopulmonary resuscitation following performance and cognitive testing. Course participants must be able to perform CPR on recording mannikins. Individual, team, and infant procedures will be taught.

(See March OSMAgram for application blank)



obituaries

James F. Beattie, M.D., Columbus; Ohio State University College of Medicine, 1954; age 47; died January 30; member OSMA and AMA.

Drew L. Davies, M.D., Columbus; Ohio State University College of Medicine, 1924; age 77; died February 16; member OSMA and AMA.

John A. Glorioso, M.D., Lima; Dalhousie University of Medicine, Nova Scotia, 1937; age 64; died February 9; member OSMA and AMA.

Sheldon G. Green, M.D., Cleveland; Ohio State University College of Medicine, 1955; age 46; died February 2; member OSMA.

George Henderson, M.D., Cadiz; Ohio State University College of Medicine, 1938; age 64; died February 19; member OSMA and AMA.

Robert H. Hoecker, M.D., Mt. Vernon; Case Western Reserve University School of Medicine, 1932; age 69; died January 26, member OSMA and AMA.

Alexander H. Kimmel, M.D., Norwalk; Ohio State University College of Medicine, 1930; age 73; died January 24; member OSMA and AMA.

William B. Ludwig, M.D., Lima; Ohio State University College of Medicine, 1942; age 71; died February 12; members OSMA and AMA.

Howard A. Martin, M.D., Toledo; University of Michigan Medical School, 1930; age 73; died February 14; member OSMA and AMA.

Willis B. Merrill, M.D., Reynoldsburg; Ohio State University College of Medicine, 1925; age 76; died January 20.

Homer E. Ring, M.D., Bellaire; Case Western Reserve University School of Medicine, 1925; age 75; died February 2; member OSMA and AMA.

Henri Schmid, M.D., Allison Park, Pa.; University of Pittsburgh School of Medicine, 1910; age 94; died February 6; member OSMA and AMA.

Hans Ludwig Spiro, M.D., Columbus; Justus-Liebig University Giessen, Hessen, Germany, 1930; age 73; died January 29; member OSMA and AMA.

Charles Stroffregen, M.D., Cleveland, University of Cincinnati College of Medicine, 1910; age 90; died January 30; member OSMA and AMA.

Frank M. Trump, M.D., Seminole, Florida; Case Western Reserve University School of Medicine, 1922; age 80; member OSMA and AMA.

Homer D. Underwood, M.D., Van Wert; Case Western Reserve University School of Medicine, 1936; age 65, died February 2; member OSMA and AMA.

Charles Williams, M.D., Marietta; University of Cincinnati College of Medicine, 1912; age 85; died February 3, 1976; member OSMA and AMA.

County Society Roster

FIRST DISTRICT

Councilor: Stephen P. Hogg, M.D., 250 Wm. Howard Taft Rd., Cincinnati 45219.

ADAMS: William J. Lundy, M.D., President, 522 E. Main St., West Union 45693; Nora V. Ancheta, M.D., Secretary, 39 Vine St., Peebles 45660; Second Tuesday.

BROWN: Philip A. Pfalzgraf, Jr., M.D., President, 1830 Ohio Pike, R.D. #1, Batavia 45103; Gene Conway, M.D., Secretary-Treasurer, Brown Co. General Hospital, Home St., Georgetown 45121; First or Second Sunday.

BUTLER: Lawrence H. Linder, M.D., President, 701 N. University Blvd., Middletown 45042; Jack L. Harris, M.D., Secretary, 3002 McGee Ave., Middletown 45042; Mrs. Joan Williams, Executive Secretary, 111 Buckeye St., Hamilton 45011, Phone: (513) 893-1410. Fourth Wednesday.

CLERMONT: James E. MacMillan, M.D., President, 75 Powhattan Dr., Milford 45150; Wm. Blake Selnick, D.O., Secretary-Treasurer, 2nd & E. Loveland Ave., Loveland 45140; Third Wednesday.

CLINTON: Thomas M. Faehnle, M.D., President, 88 N. Howard St., Sabina 45169; Foster J. Boyd, M.D., Secretary, 644 W. Main St., Wilmington 45177.

HAMILTON: Neal N. Earley, M.D., President, 6575 Devonwood Dr., Cincinnati 45224; Stewart B. Dunsker, M.D., Secretary, 506 Oak St., Cincinnati 45219; William J. Galligan, Executive Secretary, 320 Broadway, Cincinnati 45202, Phone: (513) 721-2345.

HIGHLAND: Glenn B. Doan, M.D., President, 528 South St., Greenfield 45123; Walter Felson, M.D., Secretary-Treasurer, 357 South St., Greenfield 45123.

WARREN: Dale D. Hubbard, M.D., President, 116 Warren Ave., Franklin 45005; Howard G. Berninger, M.D., Treasurer, 109 Oregonia Rd., Lebanon 45036; Second Tuesday.

SECOND DISTRICT

Councilor: W. J. Lewis, M.D., 2567 Far Hills Ave., Dayton 45419

CHAMPAIGN: Theodore E. Richards, M.D., President, 848 Scioto St., Urbana 43078; John H. Flora, M.D., Secretary-Treasurer, 848 Scioto St., Urbana 43078; Second or Third Wednesday.

CLARK: Robert A. McLemore, M.D., President, 444 W. Harding Rd., Springfield 45504; James Gianakopoulos, M.D., Secretary, 34 W. High St., Springfield, 45502; Dalia Remys, Executive Secretary, 444 W. Harding Rd., Springfield 45504, Phone: (513) 399-2830; Third Monday.

DARKE: Leroy Steinbrecher, M.D., President, 1117 South Towne Ct., Greenville 45331; Peter H. Mulder, M.D., Secretary, Arcanum Medical Center, 602 N. Main St., Arcanum 45304; Third Tuesday.

GREENE: Edward P. Call, M.D., President, 1142 N. Monroe Dr., Xenia 45385; Quirino B. Valeros, M.D.,

Secretary-Treasurer, 1450 Hanes Rd., Xenia 45385; Mrs. Virginia Jones, Executive Secretary, 1003 Parnell Dr., Xenia 45385, Phone: (513) 372-8011 Ext. 287.

MIAMI: Elihu R. Morlidge, M.D., President, 304 N. Hyatt St., Tipp City 45371; Richard Burk, M.D., Secretary, 550 Summit Ave., Suite #6, Troy 45373; First Tuesday.

MONTGOMERY: John Worthman, M.D., President, 3080 Ackerman Blvd., Dayton 45429; Berkeley Slutzker, M.D., Secretary, 5538 Philadelphia Dr., Dayton 45415; Earl E. Shelton, Executive Director, 280 Fidelity Med. Bldg., Dayton 45402, Phone: (513) 223-3185; Third Thursday except June, July, and August.

PREBLE: John D. Darrow, M.D., President, 101 Edgewood Dr., Eaton 45230; Joseph R. Williams, M.D., Secretary-Treasurer, Hillcrest Dr., Eaton 45320.

SHELBY: George J. Schroer, M.D., President, 20 S. Main Street, Fort Loramie 45845; Edward A. Link, M.D., Secretary-Treasurer, 3rd & Michigan St., Sidney 45365; Second Tuesday of March, June, Sept. and Nov.

THIRD DISTRICT

Councilor: John C. Smithson, M.D., 521 W. Sandusky St., Findlay 45840.

ALLEN: Fred D. Rhodes, M.D., President, 825 W. Market St., Lima 45805; William T. Collins, M.D., Secretary-Treasurer, Lima Memorial Hospital, Lima 45804; Mr. Waldo Smith, Executive Secretary, Box 803, Lima 45801, Phone (419) 228-1105; Third Tuesday of month, September through May.

AUGLAIZE: Charles Steinecker, M.D., President, 1007 W. Auglaize St., Wapakoneta 45895; James Romaker, M.D., Secretary-Treasurer, 114 W. Main, Cridersville 45806; First Tuesday every second month.

CRAWFORD: Robert L. Solt, Jr., M.D., President, 140 W. Hill St., Bucyrus 44820; Keith D. Blair, M.D., Secretary-Treasurer, 140 Hill St., Bucyrus 44820.

HANCOCK: Frank R. Cosiano, M.D., President, 120 W. Foulke, Findlay 45840; Herbert A. Mahler, M.D., Secretary, 117 E. Wallace, Findlay 45840; Third Tuesday.

HARDIN: Louis A. Black, M.D., President, 405 N. Main, Kenton 43326; Larry Morris, M.D., Secretary-Treasurer, 60 Washington Blvd., Kenton 43326; Second Tuesday.

LOGAN: Koo H. Moon, M.D., President, Box #730, Bellefontaine 43311; Grant K. Varian, M.D., Secretary-Treasurer, c/o Mary Rutan Hospital, Box 100-A, 205 Palmer Ave., Bellefontaine 43311; Five meetings per year.

MARION: Joseph Geiger, M.D., President, 1040 Delaware Ave., Marion 43302; Edward Charnock, M.D., Secretary-Treasurer, Marion General Hospital, McKinley Park Dr., Marion 43302; First Tuesday of January, March, May, September, and December.

MERCER: Emiliano I. Feliciano, M.D., President,

161 S. Walnut St., St. Henry 45883; Donald R. Fox, M.D., Secretary-Treasurer, 118 W. Fulton St., Celina 45822; Third Thursday.

SENECA: Gerhard W. F. Schroeder, M.D., President, 26 Madison St., Tiffin 44883; Anthony S. Lupica, M.D., Secretary-Treasurer, 40 Clay St., Tiffin 44883; Third Tuesday.

VAN WERT: Wilmer Iler, M.D., President, Medical Arts Bldg., Fox Rd., Van Wert, 45891; Donald Hughes, M.D., Secretary-Treasurer, Van Wert Co. Hospital, Van Wert 45891.

WYANDOT: Donald P. Smith, M.D., President, Pennington St., Sycamore 44882; Konstantine K. Solacoff, M.D., Secretary-Treasurer, 777 N. Sandusky Ave., Upper Sandusky 43351; Second Tuesday.

FOURTH DISTRICT

Councilor: C. Douglass Ford, M.D., 2361 W. Bancroft St., Toledo 43607.

DEFIANCE: Homer C. Brown, M.D., President, 1132 E. Second St., Defiance 43512; Subash Mathew, M.D., Secretary-Treasurer, Defiance Clinic, 1400 E 2nd St., Defiance 43512.

FULTON: Robert S. Jessup, M.D., President, 844 S. Shoop St., Wauseon 43506; Gerald A. Perkins, D.O., Secretary-Treasurer, Rt. #1, Box 20-A, Delta 43515; First Tuesday.

HENRY: Thomas F. Moriarty, M.D., President, 651 Strong St., Napoleon 43545; K. E. Dye, D.O., Secretary, Box 5, Liberty Center 43532; First Tuesday.

LUCAS: Thomas J. O'Grady, M.D., President, 4235 Secor Rd., Toledo 43623; Frank E. Foss, M.D., Secretary, 3450 W. Central, Toledo 43606; Lee F. Wealton, Executive Director, 3101 Collingwood Blvd., Toledo 43610, Phone: (419) 246-3601; Fourth Tuesday.

OTTAWA: James I. Rhiel, M.D., President, 600 Sixth St., Port Clinton 43452; Guillermo V. Crisologo, M.D., Secretary-Treasurer, 602 E. 6th St., Port Clinton, 43452; Second Thursday.

PAULDING: William Max Miller, M.D., President, Route #3, Paulding 45879; Kirkwood A. Pritchard, M.D., Secretary-Treasurer, 119 S. Main St., Paulding 45879; Third Monday.

PUTNAM: John R. Brown, M.D., President, 310 E. Main, Ottawa 45875; Earl D. DeWitt, M.D., Secretary-Treasurer, 204 E. Sycamore, Columbus Grove 45830; First Tuesday.

SANDUSKY: Willis Damschroder, M.D., President, 116 N. Main, Gibsonburg 43431; John L. Zimmerman, M.D., Secretary-Treasurer, Memorial Hospital, Fremont 43420; Mrs. Patsy J. Reed, Executive Secretary, Memorial Hospital of Sandusky Co., Fremont 43420, (419) 332-7321. Quarterly.

WILLIAMS: Virgil N. Carrico, M.D., President, Bryan Medical Group, Inc., Bryan 43506; Richard L. Hess, M.D., Secretary-Treasurer, Bryan Medical Group, Inc., Bryan 43506; Third Tuesday of every other month.

WOOD: William F. Lord, M.D., President, 920 Conneaut, Bowling Green 43402; Manuel L. de la Serna,

Jr., M.D., Secretary-Treasurer, 640 S. Wintergarden Rd., Bowling Green 43402; Third Tuesday.

FIFTH DISTRICT

Councilor: John J. Gaughan, M.D., 7911 Detroit Ave., Cleveland 44102.

ASHTABULA: Glenn E. Eippert, M.D., President, 430 W. 25th St., Ashtabula 44004; M. Meshginpoosh, M.D., Secretary-Treasurer, 254 S. Broadway, Geneva 44041; Miss Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, Phone: (216) 998-3111; Second Tuesday.

CUYAHOGA: Frederick T. Suppes, M.D., President, Chagrin River Rd., Gates Mills 44040; Howard S. Siegel, M.D., Secretary-Treasurer, 2676 Granlun Rd., Cleveland 44122; Robert A. Lang, Ph.D., Executive Director, 10525 Carnegie Ave., Cleveland 44106, Phone: (216) 231-3500.

GEAUGA: J. Craig Martin, M.D., President, 13221 Ravenna Rd., Chardon 44024; Paul R. Zeit, M.D., Secretary-Treasurer, 13241 Ravenna Rd., Chardon 44024; Mrs. Martha Withrow, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, Phone: (216) 286-6131; Second Thursday except July and August.

LAKE: David L. Farrington, M.D., President, 4813 Glenwood Ave., Willoughby 44095; Roy E. Ronke, Jr., M.D., Secretary-Treasurer, 7110 Sandpiper Ct., Painesville 44077; Mrs. Marge McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060, Phone: (216) 255-2233; Usually Fourth Wednesday.

SIXTH DISTRICT

Councilor: C. Edward Pichette, M.D., 1019 Boardman-Canfield Rd., Youngstown 44512.

COLUMBIANA: Salvatore C. Apicella, M.D., President, 2020 E. State St., Salem 44460; Francisco Avellana, M.D., Secretary-Treasurer, 700 Main St., Wellsville 43968; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460, Phone: (216) 337-8859; Third Tuesday.

MAHONING: William E. Sovik, M.D., President, 407 Mahoning Bank Bldg., Youngstown 44503; Anthony T. Deramo, M.D., Secretary, 5701 Market St., Youngstown 44512; Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 44504, Phone: (216) 747-4956; Third Tuesday, January, March, May, September, November, & Dec.

STARK: Joseph P. Yut, M.D., President, 201 Dueber Ave., S.W., Canton 44706; Willard J. Howland, M.D., Secretary-Treasurer, Aultman Hospital, 2600 6th S.W., Canton 44710; John H. Austin, Executive Secretary, 405 4th St. N.W., Canton 44702, Phone: (216) 456-8273; Second Thursday.

TRUMBULL: Thaddeus D. McGuire, M.D., President, 2760 Parkman Rd., N.W., Warren 44485; John O. Vlad, M.D., Secretary-Treasurer, 2925 Youngstown Rd.,

(continued on page 256)

County Society Roster *(continued)*

S.E., Warren 44484; Mrs. Kay Ticknor, Executive Secretary, P.O. Box 1328, Warren 44482, Phone: (216) 394-4556; Third Wednesday, September through May.

SEVENTH DISTRICT

Councilor: Robert E. Rinderknecht, M.D., 404 N. Walnut St., Dover 44622.

BELMONT: Felipe V. Lavapies, M.D., President, 342 Jefferson St., Tiltonsville 43963; Nermin D. Lavapies, M.D., Secretary, 342 Jefferson St., Tiltonsville 43963; Third Thursday except January, July, and August.

CARROLL: Carl Lincke, M.D., President, 159 Second St., Carrollton 44615; Charles H. Dowell, M.D., Secretary-Treasurer, 207 W. Main St., Carrollton 44615; Third Tuesday.

COSHOCTON: Myeong-Sang Lee, M.D., President, 636 Chestnut St., Coshocton 43812; Myron Satski, M.D., Secretary-Treasurer, 149 S. Bridge St. Newcomerstown 43832; Second Tuesday.

HARRISON: Elias E. Freeman, M.D., President, 232 Jamison Ave., Cadiz 43907; Eruch Karanjawala, M.D., Secretary-Treasurer, 505 Pine Valley Dr., Steubenville 43952; Quarterly.

JEFFERSON: Paul Mastros, M.D., President, 396 Shady Ave., Steubenville 43952; Lester Stein, M.D., Secretary-Treasurer, 226 N. 4th St., Steubenville 43952; Mrs. Bess Simpson, Executive Secretary, P.O. Box 655, Steubenville 43952; First Tuesday.

MONROE: Donald R. Piatt, M.D., Secretary-Treasurer, 154 S. Main St., Woodsfield 43793.

TUSCARAWAS: Carlos J. Torrent, M.D. President, 510 N. Wooster Ave., Dover 44622; Yogendra A. Shah, M.D., Secretary, 658 Boulevard, Dover 44622.

EIGHTH DISTRICT

Councilor: Richard E. Hartle, M.D., 414 E. Main St., Lancaster 43130.

ATHENS: Henry G. Croci, M.D., President, P.O. Box 928, Athens 45701; Lester A. Hamilton, M.D., Secretary-Treasurer, 400 E. State St., Athens 45701; Second Tuesday, March, June, September, and December.

FAIRFIELD: Jack Kraker, M.D., President, 414 E. Main St., Lancaster 43130; David H. Sheidler, M.D., Secretary, 1500 E. Main St., Lancaster 43130; Second Tuesday.

GUERNSEY: Dayle O. Snyder, M.D., President, 100 Clark Ct., Cambridge 43725; Zosimo T. Maximo, M.D., Secretary, 1213 Woodlawn Ave., Cambridge 43725; First Tuesday.

LICKING: Michael P. Ratterman, M.D., President, Granville Medical Center, Weaver Dr., Granville 43023; John J. Winsch, M.D., Secretary-Treasurer, 399 E. Main St., Newark 43055; Mrs. Dorothy Watson, Executive Secretary, 1320 W. Main St., Newark 43055, Phone: (614) 344-0331 Ext. 394; Fourth Tuesday except June, July and August.

MORGAN: Asia H. Whitacre, M.D., President, Chesterhill 43728; Henry Bachman, M.D., Secretary-Treasurer, 426 E. Union Ave., McConnellsville 43756.

MUSKINGUM: Edmond J. Booth, M.D., President, 2110 Maple Avenue, Zanesville 43701; George M. Kopf, M.D., Secretary, 2315 Maple Ave., Zanesville 43701; First Tuesday.

NOBLE: Frederick M. Cox, M.D., President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, M.D., Secretary-Treasurer, P.O. Box 239, Caldwell 43724.

PERRY: Ralph E. Herendeen, Jr., M.D., President, 203 N. Main St., New Lexington 43764; Alfredo G. Cruz, M.D., Secretary-Treasurer, 203 N. Main St., New Lexington 43764.

WASHINGTON: Jose C. Alba, M.D., President, 215 Marion St., Marietta 45750; Fortunato R. Macatol, M.D., Secretary, 102 Wyandotte Dr., Marietta 45750; Second Wednesday except June, July, August, & Sept.

NINTH DISTRICT

Councilor: Thomas W. Morgan, M.D., Holzer Medical Center, Box 344, Gallipolis 45631.

GALLIA: Edward J. Berkich, M.D., President, 565 Jackson Pike, Gallipolis 45631; Donald M. Thaler, M.D., Secretary, First Ave. & Cedar St., Gallipolis 45631; Second Tuesday.

HOCKING: Owen F. Yaw, M.D., President, 461 E. Second St., Logan 43138; John W. Doering, M.D., Secretary-Treasurer, 42 N. Spring St., Logan 43138.

JACKSON: E. Joseph Levine, M.D., President, 120 N. Ohio Ave., Wellston 45692; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640.

LAWRENCE: Radolfo J. Canos, M.D., President, P.O. Box 533, Ironton 45638; George N. Spears, M.D., Secretary, 422 S. Sixth Street, Ironton 45638; Quarterly.

MEIGS: Joseph J. Davis, M.D., President, 939 Ash St., Middleport 45760.

PIKE: William W. Wiltberger, M.D., President, 330 E. North St., Waverly 45690; Janie Hwang, M.D., Secretary, 300 Cherry St., Waverly 45690; First Tuesday.

SCIOTO: Armin A. Melior, M.D., President, Lucasville 45648; George V. Johnson, M.D., Secretary-Treasurer, 1735 Waller St., Portsmouth 45662; Lowell Thompson, Executive Secretary, P.O. Box 1348, Portsmouth 45662, Phone: (614) 354-5315; Second Tuesday.

VINTON: No active society.

TENTH DISTRICT

Councilor: J. Hutchison Williams, M.D., 4355 Sharon Ave., Columbus 43214

DELAWARE: Donald R. Thomas, D.O., President, 377 E. Williams St., Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, 6 S. Main St., Magnetic Springs 43036; Third Tuesday except June, July, and August.

FAYETTE: Joseph M. Herbert, M.D., President, 314 E. Court St., Washington C.H. 43160; Marvin H. Roszmann, M.D., Secretary, 1005 E. Temple St., Washington C.H. 43160; Second Friday.

FRANKLIN: Jack E. Tetirick, M.D., President, 3545 Olentangy River Rd., Columbus 43214; William A. Millhon, M.D., Secretary-Treasurer, 3730 Olentangy River Rd., Columbus, 43214; James S. Imboden, Executive Director, 600 S. High St., Columbus 43215, Phone: (614) 224-6116.

KNOX: James Carhart, M.D., President, 812 Co-shocton Rd., Mt. Vernon 43050; James Risko, M.D., Secretary-Treasurer, 307 Vernedale Dr., Mt. Vernon 43050; First Wednesday.

MADISON: C. Terrill Hay, M.D., President, 214 Elm St., London 43140; Brawley Arikawa, M.D., Secretary-Treasurer, 214 Elm St., London 43140; Four meetings a year.

MORROW: Joseph P. Ingmire, M.D., President, 28 W. High St., Mt. Gilead 43338; John T. Sweeney, M.D., Secretary-Treasurer, 46 S. Main St., Mt. Gilead 43338; First Tuesday.

PICKAWAY: Charles R. Hedges, M.D., President, 610 Northridge Rd., Circleville 43113; Francis W. Anderson, M.D., Secretary-Treasurer, 630 Northridge Rd., Circleville 43113; Second Tuesday.

ROSS: John F. Seidensticker, M.D., President, 612 Central Center, Chillicothe 45601; David H. Ater, M.D., Secretary, 612 Central Center, Chillicothe 45601; First Thursday.

UNION: John B. Ziegler, M.D., President, R.D. #4, Marysville 43040; May B. Zaugg, M.D., Secretary-Treasurer, Rt. #5, 18008 Timber Trails, Marysville 43040; First Tuesday, Feb., April, Oct., and Dec.

ELEVENTH DISTRICT
Councilor: Robert G. Thomas, M.D., 630 East River St., Elyria 44035.

ASHLAND: Charles H. Warne, M.D., President, 350 Hillcrest Dr., Ashland 44805; Charles A. Slagle, D.O., Secretary-Treasurer, 350 Hillcrest Dr., Ashland 44805; First Thursday.

ERIE: Harry L. Hoffman, M.D., President, 1634 Sycamore Line, Sandusky 44870; Charles J. Everett, M.D., Secretary, 409 Seneca, Huron 44839; Mrs. David Wolfert, Executive Secretary, Scheid Rd., Box 381 E., Huron 44839, Phone: (419) 433-3097; Second Tuesday except July and August.

HOLMES: William A. Powell, M.D., President, 9 W. Adams St., Millersburg 44654. . Paul Roth, M.D., Secretary-Treasurer, N. Main St., Killbuck 44637; Fourth Monday.

HURON: William B. Holman, M.D., President, 257 Benedict Ave., Norwalk 44857; Shan A. Mohammed, M.D., Secretary, 3 Milan Manor Dr., Milan 44846; Second Wednesday, Feb., April, June, Oct. and Dec.

LORAIN: Charles Jean Cooley, M.D., President, Oberlin Clinic, Inc., 224 W. Lorain St., Oberlin 44074; Lawrence G. Thorley, M.D., Secretary-Treasurer, 425 Rock Ck. Run, Amherst 44001; Mrs. Gladys Davidson, Executive Secretary, 1480 N. Ridge Rd., E., Elyria 44035, Phone: (216) 324-3093 or (216) 233-6561; Second Tuesday except June, July, August.

MEDINA: Peter Volodkevich, M.D., President, Medina Community Hospital, 990 E. Washington St., Medina 44256; William D. Robertson, M.D., Treasurer, 750 E. Washington St., Medina 44256; John E. Gerding, Executive Secretary, 3377 Forest Hills Dr., Medina 44256, Phone: (216) 725-5331; Third Thursday, January, February, March, April, May, October, and November.

RICHLAND: Bruce D. Auchard, M.D., President, 74 Wood St., Mansfield 44903; Eugene Sherman, M.D., Secretary-Treasurer, 295 Glessner Ave., Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903, Phone: (419) 522-3411; Third Thursday, except June, July, and August.

WAYNE: Thomas M. Graves, M.D., President, 1740 Cleveland Rd., Wooster 44691; Walter H. Kearney, M.D., Secretary-Treasurer, 1740 Cleveland Rd., Wooster 44691; Second Wednesday.

TWELFTH DISTRICT
Councilor: William Dorner, Jr., M.D., 750 W. Market St. Akron 44303.

PORTAGE: Robert B. Arnold, M.D., President, 449 S. Meridian, Ravenna 44266; Alif A. Kuri, M.D., Secretary-Treasurer, 250 S. Chestnut St., Ravenna 44266; Second Tuesday.

SUMMIT: Rocco M. Antenucci, M.D., President, 725 S. Cleveland Ave., Mogadore 44260; H. Wendell King, M.D., Secretary, 185 W. Cedar St., Akron 44307; Jan Armstrong, Executive Secretary, 430 Grant St., Akron 44311, Phone: (216) 376-6801; First Tuesday, January, March, May, September, and November.

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FOR INFORMATION REGARDING the wide range of opportunities for physicians (all specialties) within the Army Medical Department—contact CPT McGrath or CPT Engle, 530 Buckingham St., Columbus, Ohio 43215 or call collect (614) 221-5861 ext. 264/267. Salary range \$32,000 and up, plus fringe benefits.

WANTED: Internists—General or with special interests in pulmonary or cardiology to join busy practice in Ohio. Offering \$40,000, malpractice insurance, free overhead expenses, partnership in two years. All correspondence should be addressed to Florencio E. Yuzon, M.D., 480 Park Ave., Amherst, Ohio 44001.

PHYSICIAN desired to take over Family Practice office. Practice established in same location 20 years. Contact David J. Spangler, M.D., 3131 Sullivan Avenue, Columbus, Ohio 43204. Telephone 614/274-9095.

HOSPITAL IN-SERVICE OHIO LICENSED PHYSICIANS urgently needed for a community hospital in Northeastern Ohio. Must be board qualified with a minimum of two years approved U.S. residency. \$36,000 annually. 44 hrs/wk. Paid malpractice, Blue Cross and other fringe benefits. Contact Dr. O. Reyes 216/449-4500.

PATHOLOGIST seeks association of group practice. Contact: M. P. Mehta, M.D., 12000 Fairhill Road, Apt. 203, Cleveland, Ohio 44120. Phone 216/229-7939.

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Physician for **OHIO STATE INSTITUTE FOR MENTAL RETARDATION**—opening immediately available for qualified physician on full or selected time basis at center for mental retardation. Either contract or supplemental pay scales. Salary negotiable. Family practice, pediatrics, internal medicine, neurology backgrounds most acceptable. Contact J. F. Quilty, M.D., Medical Director, Columbus State Institute, 1601 W. Broad Street, Columbus, Ohio 43223. Telephone 614/272-0509.

INTERNIST, ORTHOPEDIST, OBSTETRICIAN-GYNECOLOGIST wanted to join growing prepaid group practice program. Competitive income. Excellent fringe benefits. Write or call collect: Sam Packer, M.D., Medical Director, 2475 E. Boulevard, Cleveland, Ohio 44120, Phone 216/795-8000.

ORTHOPEDIC SURGEON, FAMILY PRACTITIONERS needed by 40-physician multispecialty group practice. Modern, excellently equipped building adjacent to 265-bed acute-care hospital in southeastern Ohio. Excellent benefits, paid liability insurance, salary negotiable. Contact: Robert E. Daniel, Administrator, (614) 446-5187 Collect; or write Holzer Medical Center Clinic, P.O. Box 344, Gallipolis, Ohio 45631.

UNIQUE OPPORTUNITY! A for-profit physician corp. which operates an inner-city private practice in conjunction with a community health center and has strong ties with University of Cincinnati College of Medicine is in need of a fulltime OB/GYN and also an Internal Medicine/Family Practice Physician. Contact Charles O. Dillard, M.D., Walnut Hills-Evanston Medical Center, 3036 Woodburn, Cincinnati, Ohio 45206 or call 513/281-4116.

LOOKING FOR ASSOCIATE-PARTNER, for very well established general practice (OB and minor surgery helpful) with possibility of taking practice over in the future. Very busy SE part of Ohio, at intersection of I-77 and I-70, with two lakes nearby (one of them is the largest in State of Ohio). Excellent recreational and school facilities, including college facilities. Please write, giving training and qualifications, to Box 763, c/o Ohio State Medical Journal.

WANTED: CHILD PSYCHIATRIST: Full or Part Time. Medical Director, Willson Children's Community Mental Health Center. Send Resume 785 N. Park St., Col. O. 43215.

FAMILY PRACTITIONER needed for Branch Clinic of 40-physician multispecialty group practice clinic located in Southeastern Ohio. Branch Clinic will be constructed in mid-1976, operations to start in fall 1976. Excellent benefits, paid liability insurance, salary negotiable. Contact: Robert E. Daniel, Administrator, (614) 446-5187 Collect; or write Holzer Medical Center Clinic, P.O. Box 344, Gallipolis, Ohio 45631.

EMERGENCY PHYSICIANS: Full time, career-oriented, Northeast Ohio. \$46,000 plus for 48 hour week. Additional compensation commensurate with experience and training. Liberal fringe benefits, including malpractice insurance. Full department status. Ohio lic. req. Write J. J. Cahill, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094. Phone 216/946-4546.

ASSOCIATES WANTED: Cincinnati based professional corporation seeks full or part-time associates. Openings available in Emergency rooms, community clinics, or Industrial Medical Centers. Medical Health Services, Inc., 5002 Ridge Ave., Cincinnati, Ohio 45209. Phone: 513/631-0200.

Two board-certified **FAMILY PRACTITIONERS DESIRE ASSOCIATE.** New office building under construction adjacent to 325 bed hospital. Central Ohio location approximately 40 miles from major univ. medical center. Salary negotiable, liberal fringe benefits. Send curriculum vitae to Box 764, c/o Ohio State Medical Journal.

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WANTED GENERAL PSYCHIATRIST: Full time, to join a Formative Clinic in the suburbs of Akron. For salary and fringe benefits please contact Abdon E. Villalba, M.D., A. E. Villalba, Inc., Oakwood Professional Center 2341 Oakwood Dr., Cuyahoga Falls, Ohio 44221. Phone 216/929-3956 or 929-3829.

FOR RENT MANSFIELD, OHIO: Medical suite in a beautiful, modern medical building. 3 blocks from General Hospital. Reception room furnished and draperies throughout. Contact Robert E. Klein, D.D.S., 117 Sturges Avenue, Mansfield, Ohio 44903. Phone 419/524-9990.

DIRECTOR: DEPARTMENT OF FAMILY PRACTICE—Board certified or qualified for 350-bed community hospital to develop and administer such a program. Salary commensurate with qualifications. Please contact and plan to interview J. R. Paradise, M.D., Director of Medical Education, St. Alexis Hospital, 5163 Broadway Avenue, Cleveland, Ohio 44127; Phone: 216/441-3300 Ext. 246.

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EMERGENCY MEDICINE: Career opportunities available in E.D. medicine. Also short-term and locum tenens. Eight Ohio locations. Flexible work schedules and competitive remuneration. Paid malpractice, vacation, educational leave. Contact Doctor S. Spurgeon or J. W. Cooper toll-free 1-800-325-3982.

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(216) 653-6300

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Full-time position in 30-person city-county health department for physician, preferably with public health experience. Position should interest middle-age G.P. or Internist (45-55) who desires to reduce work load. Starting salary would not be less than \$35,000 plus fringe benefits. Contact M. C. McCuskey, M.D., Health Commissioner, Guernsey County General Health District, 326 Highland Avenue, Cambridge, Ohio 43725; Phone 614/439-3577.

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Auxiliary

MRS. S. L. MELTZER, Communications Chairman

Come May 10, 11, and 12, Ohio roads will be converging on Cincinnati and the 36th Annual Convention of the OSMA Auxiliary at the Terrace Hilton Hotel. Convention spells fun and camaraderie, but, even more importantly, it spells meaningful Auxiliary business. It zeroes in on important services for the medical profession and the state's individual communities.

The May 10 Board Luncheon and subsequent pre-convention Board meeting will bring together the outgoing and incoming members of the Board (this procedure has been followed in recent years and has been found an ideal way of indoctrinating the newcomers). The first business session of the convention will begin at 9 AM Tuesday morning, the 11th. The AMA Auxiliary's representative will be Mrs. Chester Young of Kansas, Second Vice-President. Tuesday afternoon's "What's Cooking?" feature should be one of the most rewarding sessions at the convention. It spotlights the county presidents and the outstanding activities of their groups.

This 1976 Convention will witness, for the first time, the Hamilton County Auxiliary as convention hostess at the same time one of its members, Mrs. Robert E. Krone, is state president. Mrs. William Myers of Pickaway County will be installed as the 1976-1977 president at Wednesday's luncheon. The Wednesday morning breakfast will feature a talk by Robert Holcomb, OSMA Field Service Director. He will discuss the implications of Public Law

96-641, the National Health Planning and Resources Development Act of 1974.

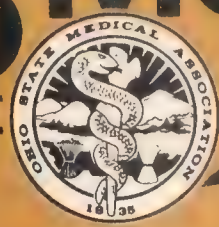
The Gavel Club, whose members are past state presidents, will also hold its annual get-together on Wednesday morning. Tickets may be purchased for Wednesday's breakfast (\$2.00); Wednesday's luncheon (\$5.50); OMPAC luncheon (\$8.00); and the Monday night dinner at the Bankers' Club for auxiliaries, their husbands, and other guests (\$10.50).

I must not omit mention of two important Hamilton Auxiliary members: Mrs. Manuel Rodarte and Mrs. Charles D. Hafner, Chairman and Cochairman of Convention 1976.

Here are the names of some other hard-working gals on the innumerable committees for this year's Big Event: Mrs. Robert Niehaus, Finance; Mrs. Emil Barrows, Guests; Mrs. Richard Wurzelbacher and Mrs. Clyde Rolf, Hospitality; Mrs. Edward Rowat, Liaison; Mrs. Joseph Casper, OMPAC luncheon decorations; Mrs. Walter Wildman, II, Properties; Mrs. Arden Steele, Pages; Mrs. Clifford Gleaves and Mrs. Robert Slagle, Printing; Mrs. Thomas Mussio, Publicity; Mrs. Fawzy Mansour, Registration; Mrs. James Wiseman, Roll Call; Mrs. Robert Gallagher, Tickets; Mrs. Ernest Meese, Monday-night entertainment; Mrs. Richard Wendel, State Board luncheon; Mrs. Victor H. Hinrichs, Wednesday breakfast and luncheon.

MAY, 1976
Volume 72, Number 5

THE OHIO STATE Medical Journal



JOHN H. BUDD, M.D.
OHIO'S CANDIDATE FOR AMA PRESIDENT-ELECT

A PROFILE FOR PROGRESS:
JOHN H. BUDD, M.D., PAGE

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Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Physician

Have You Contributed to The OSMA Malpractice Research Fund?

The OSMA in conjunction with the OSMA Task Force on Professional Liability urges each physician in the State of Ohio to contribute at least \$100 to the OSMA Malpractice Research Fund.

This Fund will underwrite the cost of a number of projects designed to assist physicians in dealing with the present liability crisis.

All contributions are **tax-deductible** in the same manner as OSMA dues.

If you have not contributed, use either the form on this page or the envelope already mailed to you and remit your check today.

Remember: Professional liability is the concern of all physicians.

Remember: It takes support from **ALL** for a successful project.

CONTRIBUTE NOW

(See page 262 for Research Project information & names of Task Force members)

Enclosed is my contribution to the OSMA Malpractice Research Fund:

☐ Yes, I support the Fund. My \$100 is enclosed.

☐ Yes, I wish to contribute more than \$100.

My check is enclosed for ☐ \$ 200

☐ \$ 500

☐ \$1000

Name _____ County _____

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City _____ State _____ ZIP _____

Please make your check payable to OSMA Malpractice Research Fund.

Mail the check to OSMA Headquarters, 600 S. High Street, Columbus, Ohio 43215.

Malpractice Research Projects

Court Docket Survey — A data collection program designed to develop desperately needed liability statistics. This project will provide answers to many of the questions we have been asking.

Counterclaim Research Project — An investigation into what must be done to bring about legal changes that will provide a mechanism whereby physicians can more effectively countersue when faced with a malpractice case. A variety of proposed changes in state law and Supreme Court rules will be reviewed by legal experts.

Captive Malpractice Insurance Company Research Project — An in-depth analysis of the feasibility of the OSMA forming its own company to sell malpractice insurance in Ohio. This would be an alternative to current plans, especially the J.U.A. Types of companies, experiences of other states, availability of re-insurances, types and amounts of proposed policies, and management problems will all need investigation.

Actuarial Analysis — An effort to produce viable statistics which will allow the OSMA to challenge proposed malpractice rate increases by insurance companies or their filing services. Without this data, Ohio's physicians have little defense when rates continue to escalate.

Public Information Campaign — A program to educate the public to the fact that increasing malpractice costs will cause all health care costs to rise. The public must know that this is not solely a physician's problem.

OSMA Task Force on Professional Liability:

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George N. Bates, M.D.

William M. Wells, M.D.

Robert G. Thomas, M.D.

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Family Practice Boards Scheduled for October 1976

The American Board of Family Practice has announced that the next certification examination will be given October 30-31, 1976, in seven cities throughout the U.S. Information regarding the examination is available from Nicholas J. Pisacano, M.D., Executive Director and Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Lexington, Kentucky 40506. Completed applications must be received in that office no later than June 15, 1976.

Social Security Disability Program Lists 112,200 Ohioans on Roles

Under the provisions of the Social Security Disability Program, a worker under the age of 65 years can receive monthly benefits if he or she becomes unable to work due to a mental or physical impairment that has lasted (or is expected to last) at least 12 months or is expected to result in death.

Currently, 112,200 disabled workers in Ohio are receiving benefits. In addition, 20,400 wives or husbands and 63,000 children of these disabled workers receive benefits.

The latest year for which tabulated data are available showing disabled worker diagnostic pattern by state is 1972. Disabled workers in Ohio who began receiving benefits for that year constituted 23,011 of the 455,398 new beneficiaries nationwide.

In comparing the frequency of diagnostic groups in Ohio with those of the nation, it can be noted that diseases of the circulatory system comprised the largest group in the country. Disease of the musculoskeletal system and mental disorders, including psychoneurotic and personality disorders, were the second and third largest diagnostic groups, respectively. The most prevalent diagnosis in both Ohio and the nation in 1972 was chronic ischemic heart disease.

Comparison of the percentage of disabled workers in the U.S. to the percentage in Ohio for each diagnostic group for 1972 is as follows:

- | | |
|---|-----------|
| 1. Diseases of the circulatory system | 32.2/34.0 |
| 2. Diseases of the musculoskeletal system | 16.7/17.5 |

(continued on page 267)

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- ☐ PRACTICE OVERHEAD EXPENSE PROTECTION
- ☐ LIFE INSURANCE

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Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

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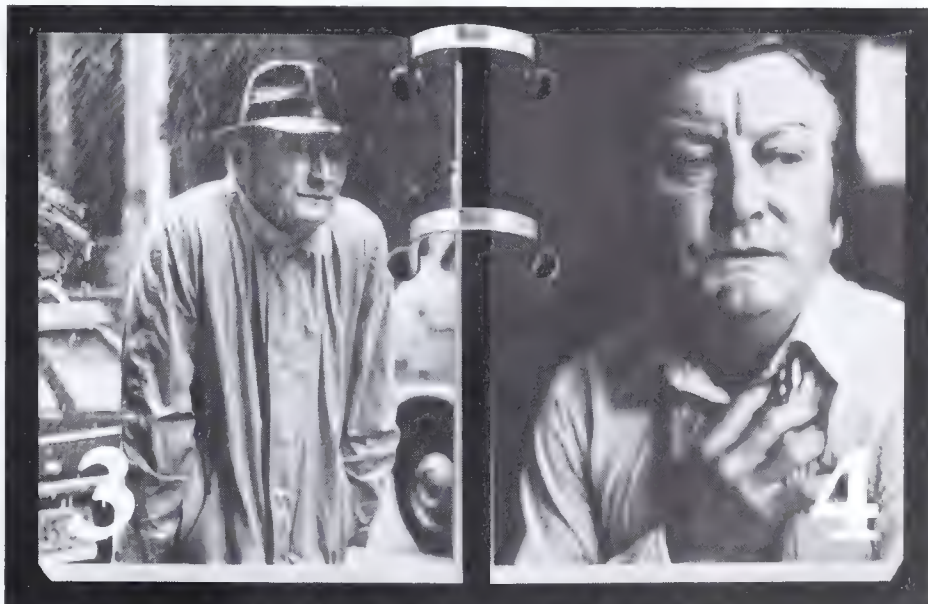
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1. Russek HI: AM J M Sc 239:478, 1960



"Pain days" significantly reduced with Cardilate® (erythrityl tetranitrate) in 48-patient study.¹ Patients on placebo experienced same pain as usual or increased pain 2 days out of 3...compared to 1 day out of 4 while on Cardilate.

Rapid-acting chewable tablets (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.



Effective prophylaxis against attacks; increases exercise tolerance. Serious side effects have not been reported in 20 years' clinical use.

Cardilate can save patients money; is less expensive than many popular long-acting nitrates. 20% to 30% savings not uncommon...also helps reduce need for nitroglycerin.



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The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.



3. Mental, psychoneurotic, & personality disorders	9.9/9.7
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5. Accidents, poisonings, and violence	7.0/7.0
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8. Endocrine system, metabolic, and nutritional diseases	3.8/3.9
9. Diseases of the digestive system	2.9/2.4
10. Infective and parasitic diseases	1.9/1.6

Upjohn Donates to O.S.U.

The Upjohn Company presented \$1,000 to the Ohio Medical Education Network (OMEN). Edwin H. Sypolt, Jr., Medical Sciences Liaison of Metabolic Diseases for The Upjohn Company, presented the check to Manuel Tzagournis, M.D., Associate Dean, The Ohio State University College of Medicine. This is the third consecutive year that The Upjohn Company has contributed to the network.

Now Apply Anytime for AMA MD's Recognition Award

Physicians may now apply for the AMA Physician's Recognition Award at any time, rather than on a three-year cycle. In the past six years, 64,149 physicians have qualified for the continuing medical education award. Beginning this year, AMA members will pay no application fee toward the award. Non-members will be charged \$25.

Foreign Medical Graduates Organize College of International Physicians

Practicing physicians educated in medical schools outside the United States recently organized the American College of International Physicians, Inc. The college will provide a forum for highly qualified international physicians and surgeons to advance the highest standards of medical education, practice, research, and ethics.

Fellowship in the college is open to all physicians who received their medical education in schools outside the U.S. and who have been licensed to practice medicine for at least three years. Associate and affiliate fellowship is open to all who do not meet these requirements.

Further information can be acquired by contacting Antonio B. Dones, M.D., president of the organization, at 3030 Lake Avenue, Fort Wayne, Indiana 46805.

Catalog of AMA CME Courses Available from AMA Headquarters

The 1976 *Catalog of AMA Continuing Medical Education Courses* lists postgraduate courses at Annual and Clinical Conventions, nine regional meetings, and several special activities, including seminars on public speaking, practice management, leadership, financial management, and writing for scientific journals. The catalog is available from the Division of Continuing Medical Studies, AMA Headquarters, 535 N. Dearborn Street, Chicago 60610.

We Salute...

The O.S.M.A. "Medical Spirit of '76!"

We are proud to be a part of this vigorous OSMA spirit. One of the advantages of your OSMA membership is the opportunity to obtain excellent insurance coverage at low group rates.

Disability Income Protection*

- Maximum benefit is \$500 weekly.
- Includes the new Rehabilitation benefit.

**This is the plan sponsored by the Ohio Academies of Medicine and Medical Societies, and co-sponsored by the OSMA.*

Group Term Life

- Maximum benefit is \$100,000.
- 44% dividend was paid for policy year ending 8/31/75.



OSMA NEW MEMBERS

The Ohio State Medical Association welcomes the following physicians who joined the society during the month of March 1976. The list indicates the county and city in which each new member is practicing or taking postgraduate work. The support of these physicians for their state organization is appreciated.

ALLEN (Lima)
Douglas Michael Daniels

ASHTABULA (Ashtabula)
Kaveripatnam C. Nagaprakash
Saraswathi Ramachandran

ATHENS (Athens)
Abdul Waheed
John Mays Worrell, Jr.

BELMONT
Nepomuceno Z. Dario,
Wheeling, W.Va.

BUTLER (Hamilton unless noted)
Kuda L. H. De Silva
J. Michael Dolibois

Chad H. Dunkle
Thomas E. Furlong, Middletown
Dan G. Niehaus

CRAWFORD (Bucyrus)
Douglas Robert Angerman, Galion
Michael Allen Johnson
Moon Ock Sohn

CUYAHOGA (Cleveland)
Carmen Mata Ebalo
James Coleman Engle
Ana Lucia Hirsch
Seth Nelson Hirschfield
Gary A. Kleinman
Jacob Frederick Palomaki
Robert Sanders Rhodes
Michael George Sheahan
Stuart Irwin Zetzer

DARKE
Philip Eugene Thuma, Arcanum
Gregory Margile Weber, Versailles

FAIRFIELD (Lancaster)
Charles Harker Cook
John Grenville O'Handley, Jr.

FRANKLIN (Columbus)
John Namer Aseff
Jin Kook Choi
Shashikala A. Gogate
Carole Ann Miller
Charles F. Mueller
David S. Postlewaite
Robert L. Ruberg
Lewis Seeder
John W. Thomas
Warren L. Wheeler

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**APATHY • IRRITABILITY
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**A GENTLE CEREBRAL
STIMULANT & VASODILATOR
FOR GERIATRIC PATIENTS**

Each CEREBRO-NICIN capsule contains:
Pentylentetrazole 100 mg. • Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg. • Thiamine HCl 25 mg.
L-Glutamic Acid 50 mg. • Niacinamide 5 mg.
Riboflavin 2 mg. • Pyridoxine HCl 3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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Thomas Lyle Mount
Ronald Arthur Pohlmeier

HARDIN (Kenton)
Larry Lee Morris
Richard Orrin Pelham

HURON
Chia Yong Chang, Norwalk
Tik Tjong Liem, Plymouth
Farid H. Said, Wakeman
Chong Kyoo Woo, Willard

LOGAN
Donald Duane Graber, Bellefontaine
George W. Horst, West Liberty

LUCAS (Toledo)
Lurley John Archambeau
Maria Helen G. Bautista
Ayse Celik
Steven Martin Dosick
Crystal Rose Goveia
David J. Greenfield
Richard F. Leighton

MARION (Marion)
Jesus V. Cutillar
Akhtar Husain

MONTGOMERY (Dayton)
Robert Arlin Goldenberg
Ronald D. Hamilton
Kenneth Patrick Levison
Jon Douglas Rahman
John C. Wright

MUSKINGUM (Zanesville)
Harjits S. Bharmota
Perry Michael Kalis

PIKE (Waverly unless noted)
Leslie Jay Boone, Sr.
Noli B. de La Pena
Ralph Allen Foulke
Edward Vale Henson, Piketon
Daniel E. Schlie

PORTAGE (Kent)
Robert Arthur Liebelt

RICHLAND (Mansfield)
Joseph Ru Lee

ROSS (Chillicothe)
Gary Alan Colner
Numberiano M. Jalbuena, Jr.

SCIOTO (Portsmouth)
Shabbir Haider
Mitchell C. Newman

SENECA (Tiffin)
David Edward Berckmueller

STARK (Canton)
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IMMEDIATE or GRADUAL

nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.

Each yellow tablet contains:

Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.

Each time-release capsule contains:

Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.

In a special base of prolonged therapeutic effect.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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obituaries

BERNARD J. DREILING, M.D., Canfield; St. Louis University School of Medicine, 1920; age 78; died February 29; member OSMa and AMA.

GAULT C. FOOR, M.D., Hillsboro; University of Cincinnati College of Medicine, 1929; age 75; died February 25; member OSMa and AMA.

JAMES S. HAWTHORNE, M.D., Elyria; State University of New York College of Medicine, 1948; age 51; died March 5; member OSMa and AMA.

EDWIN P. KENNEDY, M.D., Cleveland; Case Western Reserve University School of Medicine, 1916; age 89; died March 1; member OSMa and AMA.

FRANK A. LAWRENCE, M.D., St. Petersburg, Florida; University of Michigan Medical School, 1914; age 88; died March 6; member OSMa and AMA.

ALFRED J. LOSER, M.D., Lorain; University of Budapest, Hungary, 1919; age 81; died February 24; member OSMa and AMA.

JAMES F. MACHWART, M.D., Medina; Case Western Reserve University School of Medicine, 1920; age 83; member OSMa and AMA.

JACK MERCER, M.D., Chapel Hill, North Carolina; Case Western Reserve University of Medicine, 1948; age 50; died February 21; member OSMa and AMA.

JOSEPH J. MILLER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1948; age 54; died August 24, 1975; member OSMa and AMA.

CLYDE W. MUTER, M.D., Warren; Ohio State University College of Medicine, 1938; age 65; died February 24; member OSMa and AMA.

DELBERT J. PARSONS, M.D., Springfield; Indiana University School of Medicine, Indianapolis, 1939; age 64; died March 6; member OSMa and AMA.

ROBERT M. RAWDON, M.D., Cincinnati; Tulane University School of Medicine, New Orleans, 1941; age 59; died March 6; member OSMa.

DAVID E. RICHARDS, M.D., Cleveland; Case Western Reserve University College of Medicine, 1967; age 35; died February 24; member OSMa.

THOMAS C. A. SHERIDAN, M.D., Dayton; Medical College of Virginia Health Sciences, Div. of Virginia Commonwealth University, 1920; age 83; died January 10; member OSMa and AMA.

BESSIE G. WIESSTIEN, M.D., Cleveland; Medical College of Pennsylvania, 1915; age 84; died February 27; member OSMa and AMA.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Before prescribing, please consult complete product information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
 "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
 Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

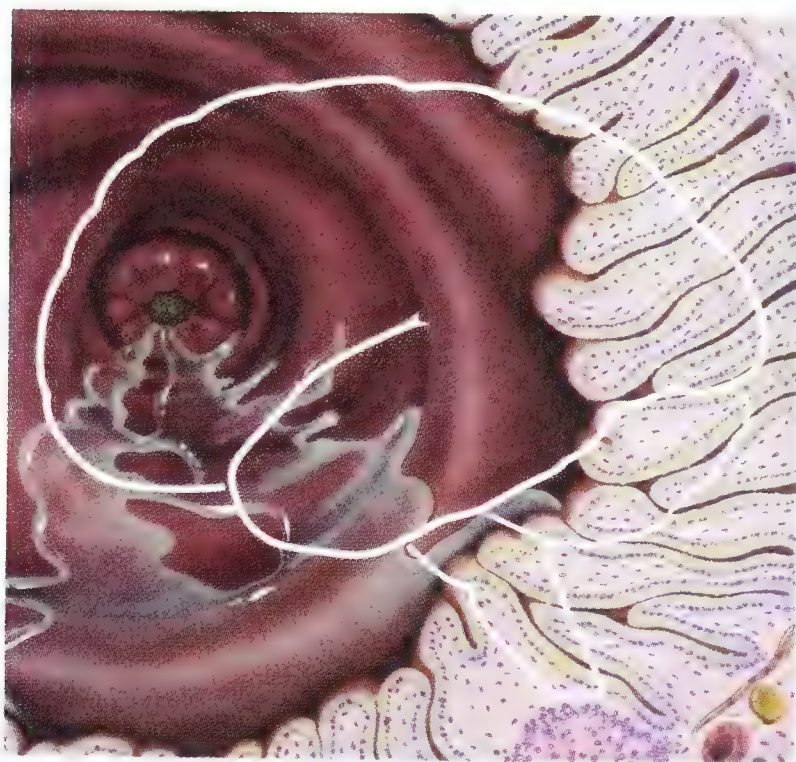
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Because irritable bowel syndrome*
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Dual-action
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Each capsule contains 5 mg chlordiazepoxide HCl
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1 or 2 capsules t.i.d. or q.i.d.

A distinctive
antianxiety-anticholinergic
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with the economy and convenience of a single medication.

*This drug has been evaluated as possibly effective for this indication. Please see preceding page for brief summary of product information.

Support the AMA

There was a Man born who could walk on water. Yet, Peter, a disciple, tried to do the same, but lacked faith. When he tried to walk on the same waters, he faltered and began to sink. The Man reached out his hand and saved Peter. This is a parable, but I believe it.

There is a similar hand reaching out to save us. It comes from the strongest of all medical organizations. This organization is not made of gods, but of men with similar backgrounds to ours. They may not always take the course that you believe is right, but if you do not make an effort to advise them they can be misdirected. However, they attempt to fulfill the wishes and desires of the majority.

The AMA can only hear your voice if you become a member. As a member you may present your views, submit a resolution; and your delegates will fight for you. This has happened many times, beginning as a simple statement in a county medical society and blossoming out into a momentous decision.

In spite of the many criticisms, the AMA in 1975—

(1) has forced the Federal Government to withdraw the regulations in utilization review;

(2) has sued HEW on maximum allowable cost control for drugs;

(3) defeated the attempt to control residencies by federal restrictions;

(4) established a department of negotiations to deal with any third party interference between patient and doctor.

(5) will act to ease the professional liability insurance.

(6) supports the physician to be free to practice in accordance with his professional judgment with the right to fee for service;

(7) has convinced Congress to increase the retirement plan to 15 percent of earned income or \$7,500 a year, whichever is less (Keogh Plan);

(8) protects against any change in the original HMO law that encourages favorite treatment by the Federal Government over any other service, e.g., fee for service.

These are but eight of the many favorable actions the AMA has taken for you. These are not parables. These are facts! I believe this. Don't you? Grasp the hand that is stretched out to save you. Support the AMA so that you too can be heard.

William E. Sovik, M.D.
President, Mahoning County
Medical Society

(Reprinted from the *Bulletin of the Mahoning County Medical Society*, Volume XLVI, No. 2)

AMA Past-President Praises *Your Doctor Reports*

One of the great recompenses for my work as president of the American Medical Association was the privilege of making fine friends such as the officers of the Ohio State Medical Association.

Your monthly bulletin has been fine—and now you *Your Doctor Reports* is magnificent—just wish all our state Associations had such.

Milford O. Rouse, M.D.
AMA Past President
Dallas, Texas



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New York Claims First Caesarean Section

In your December, 1975, issue (*The Journal*), John A. Richmond, M.D., reports a Caesarean Section which was performed on April 22, 1827. It is claimed that this is the first recorded Caesarean Section in this country.

New York State can lay claim to an earlier recorded Caesarean Section even more interesting in that it was self performed." This case is so unusual that I quote from page 67 of the *Transactions of the Medical Society of the State of New York*, 1857, as follows:

In the year 1823, when President of the Rensselaer County Medical Society, to which office he had been elected the second time, Dr. McClellan communicated to that society that singular case of self performed caesarean section on the person of a mulatto girl living in Nassau. Twins were extracted—the wound cleansed and properly dressed, and the girl recovered. The time chosen for the operation was while the family were at dinner; the place, behind the barn on a snow bank—and her instruments, her master's razor and a darning needle. The case was copied into several medical journals. It was first published in the New-York Medical and Physical Journal for March, 1823, page 41, to which journal it was sent by order of the Rensselaer County Medical Society.* It was also published in the London Medico-Chirurgical Review, vol. 5 (1823), page 236. The editors of the latter journal doubted the correctness of the story. It was nevertheless true, and only tends to show how tenacious of life the human body sometimes is, and to what extreme injuries it may be subjected, and still, life continue, and health be restored. Dr. Bassett, whose patient she was, is still living as the subjoined letter will prove:

Nassau, N. Y., January, 1857

My Dear Doctor:

The obstetric case referred to in your's of the 11th inst., occurred January 29, 1821. The wound healed by the first incision. Bleeding was resorted to, once. There was suppression of urine which required the use of the catheter for about a week. These with laxatives completed the cure in about 20 days. She left Nassau the May following perfectly well. Six years after I saw her in Troy. She was living with a Mr. Rogers in the capacity of a servant girl. Since then I have not heard of her.

With respect, truly yours,
E. D. BASSETT

Dr. T. W. Blatchford.

* "At the semi-annual meeting of the Rensselaer County Medical Society, convened at Troy (N.Y.), January 4, 1823.

"Resolved, That the secretary be requested to transmit a copy of the report of a case of self-performed caesarean section, reported this day by Dr. Samuel McClellan, President of said society, to the editors of the Medical and Physical Journal, New-York, and to the editors of the New England Journal of Medicine and Surgery, Boston, and request an insertion thereof in their respective journals."—Extract from the minutes.

ASAPH CLARK, Sec'y.

On the basis of this report I submit that the first Caesarean Section (recorded) was performed in the Empire State and not in the Western Reserve.

George J. Lawrence, Jr., M.D.
Director,
Division of Scientific Activities
Medical Society of the State of New York

Comment:

For those MDs who have performed emergency classical cesarean sections and know how difficult the opening of the peritoneal cavity can be on occasion with little or no anesthetic; how difficult the displacement of the intestines may be without anesthetic; how troublesome the urinary bladder can become when distended; and the problems associated with surgically entering the superior aspect of the uterine cavity through a thickened myometrium with placental attachment, the miracle of the reported "self performed caesarean section" of January 29, 1821, is truly remarkable.—To our New York colleague, my thanks for the historical report.

R. L. Meiling, M.D.
Consulting Medical Editor



Accredited by Joint Commission on Accreditation of Hospitals.

GUY H. WILLIAMS, Jr., M.D.
Medical Director

G. PAULINE WELLS, R.N.
Admin. Director

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

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High on a Hill-Top, Overlooking Beautiful
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Booklet available on request.

HERBERT A. SIHLER Jr.
President

COLLEAGUES IN THE NEWS ...

MICHAEL ALTMAN, M.D., Acting Director, Division of Pulmonary Diseases, The Ohio State University Hospitals, was recently elected to the Board of Directors of the Ohio Lung Association (OLA) as Director-at-Large. OLA is the state affiliate of the American Lung Association, formerly the National Tuberculosis and Respiratory Disease Association.

The following Ohioans have been appointed or reappointed to American Academy of Family Practice commissions and committees: **DAVID A. BARR, M.D.**, Lima; **ROSS R. BLACK II, M.D.**, Akron; **B. LESLIE HUFFMAN, JR., M.D.**, Maumee; **HARRY A. KILLIAN, M.D.**, Mentor; **FRED V. LIGHT, M.D.**, Cleveland; **ROGER A. PEATEE, M.D.**, Bowling Green; and **RAYMOND SATTler, M.D.**, Cleveland.

Twenty-four psychiatrists from universities and hospitals throughout the U.S. will make up the faculty for the Lederle Distinguished Lecturer Series in Psychiatry. Representing Ohio are **BARRY BLACKWELL, M.D.**, Dayton, and **MILTON KRAMER, M.D.**, Cincinnati.

Dr. Blackwell is Professor of Psychiatry and Associate Professor of Pharmacology at the University of Cincinnati. He also serves as Director of the Psychosomatic Unit at Cincinnati General Hospital and Chairman of Psychiatry at Wright State Medical School.

Dr. Kramer is Professor of Psychiatry and Associate Director for Research at the University of Cincinnati.

The Board of Trustees of Northeastern Ohio Universities College of Medicine approved financial agreements with The Youngstown Hospital Association and St. Elizabeth Hospital for the development of training programs in pediatric and general surgery and the preparation for integration of undergraduate medical students into the hospital curriculum.

JOHN BLEACHER, M.D., The Youngstown Hospital Association, has been appointed part-time Director of Pediatric Surgery to strengthen graduate training programs by organizing and supervising the hospital's pediatric surgery service.

GERALD KLEBANOFF, M.D., St. Elizabeth Hospital, was similarly appointed part-time Director of General Surgery.

JOHN D. BRUMBAUGH, M.D., Akron, has been appointed to his third consecutive five-year term as a member of the Akron Health Department. Dr. Brumbaugh was also reelected to his sixth term as President of the Board of Trustees of the Akron Museum of Natural History and is presently in his 21st consecutive year on the Ohio State Medical Board.

HENRY G. CRAMBLETT, M.D., of the Ohio State University has been elected to the nine-member Board of Directors of the Federation of State Medical Boards. The federation developed the uniform examination now used in 49 states for licensing physicians.

Dr. Cramblett is Ohio State's Acting Vice-President for Medical Affairs and Dean of the College of Medicine. Dr. Cramblett also has been a member of the State Medical Board of Ohio since 1970 and served as its president in 1974.

ROBERT S. DANIELS, M.D., Dean of the College of Medicine and Professor of Psychiatry at the University of Cincinnati, has been appointed to the National Advisory Mental Health Council. Health, Education, and Welfare Secretary David Mathews announced this appointment, the term of which will end September 30, 1979.

Dr. Daniels received his medical degree from the University of Cincinnati and served his internship at Cincinnati General Hospital and his psychiatry residency at the university. He is a member of the American Group Psychotherapy Association and the AMA.

C. JOSEPH DELOR, M.D., has been named to the Warner M. and Lora Kays Pomerene Professorship in Medicine at The Ohio State University College of Medicine. The chair is to be held by those engaged in the education and training of physicians in family medicine. A Professor of Medicine at University Hospitals since 1963, Dr. DeLor is also Director of General Medicine and Coordinator of the Medical Specialty Clinics at the hospitals.

MELVIN L. ECKHOUSE, M.D., Maple Heights, was recently appointed Assistant Clinical Professor at Case Western Reserve University School of Medicine.

FERENC HUTTERER, M.D., has been named Program Chief and Professor of Molecular Pathology and Biology for Northeastern Ohio Universities College of Medicine.

Dr. Hutterer was formerly Professor of Pathology at Mount Sinai School of Medicine, City University of New York, and Director of the Department of Chemistry at Mount Sinai Hospital in New York.

JOHN C. JONES, M.D., Chairman of the Department of Medical Education at Akron General Medical Center, has been named Chairman of the Council of Coordinators of Graduate Medical Education for Northeastern Ohio Universities College of Medicine.

Dr. Jones was in private practice in Cuyahoga Falls from 1965 to 1970, when he became the full-time Director of Medical Education at Akron General Medical Center. He is also a consultant in the treatment of diabetes and a member of the Special Admissions Committee for Fifth Pathway students at Case Western Reserve University.

DAVID P. NICHOLSON, M.D., Professor, Department of Medicine, Wright State University School of Medicine, was Visiting Professor at Nottingham University Medical School, England. He also served as Guest Lecturer at the annual meeting of the British Thoracic and Tuberculosis Association in Brighton, England.

STANLEY W. OLSON, M.D., Provost, Northeastern Ohio Universities College of Medicine, has been elected to Distinguished Service Membership in the Association of American Medical Colleges (AAMC). This category of membership in the AAMC was established in 1974 to recognize the contributions to medical education of those members who have had long association with the AAMC.

Dr. Olson has served as Dean and Professor of Medicine of the University of Illinois College of Medicine and Medical Director of the University of Illinois Research and Education Hospital, Chicago; Dean and Professor of Medicine of Baylor University College of Medicine, Houston; and Professor of Medicine and Director of the Tennessee Mid-South Regional Medical Program at Vanderbilt University and Meharry Medical College.

He was national director of Regional Medical Programs from 1968 to 1970, after which he became President of the Southwest Foundation for Research and Education in San Antonio, Texas.

PETE N. POOLOS, JR., M.D., Cleveland, has been elected President of the Northeastern Ohio Neurosurgical Society. This group is composed of physicians in both academic and private practice of medicine throughout northeastern Ohio and western Pennsylvania. The society has promoted continuing medical education in neurosurgery and has maintained professional excellence within the area of neurological surgery.

Other officers elected are **EDWARD BISHOP, M.D.**, president-elect; **RUSSELL HARDY, M.D.**, secretary; and **DAVID LEHTINEN, M.D.**, treasurer.

The American College of Cardiology, a 6,900-member organization of cardiovascular scientists, has named **DAVID C. SCHWARTZ, M.D.**, Cincinnati, to its Board of Governors. Dr. Schwartz will be responsible for the activities of the College within Ohio. The objective of the College is to promote public welfare by education directed toward the prevention of diseases of the circulatory system and to encourage continuing education in cardiology for physicians and other scientists in fields related to the circulatory system.

JEROME F. WIOT, M.D., Cincinnati, has been elected to a three-year term on the Board of Chancellors of the American College of Radiology (ACR). He will serve as Chairman of the Commission on Diagnostic Radiology of the ACR.

Dr. Wiot has also been named Assistant Editor of *Cardiopulmonary Commentary*, a new quarterly cassette tape journal of the American College of Chest Physicians. This publication will be devoted to the evaluation and clinical interpretation of selected articles from current issues of the College's main publication, *Chest*.

Ohio Health News_____

John H. Ackerman, M.D., M.P.H.

Director of Health

Home Health Care Services

Patterns of health care delivery are rapidly changing. During acute phases of illness, the complex services of a hospital are necessary. However, the changing age composition of the U.S. population and the proportionate increase in long-term illness and disability have resulted in a recognized need to alter and improve traditional methods of delivering health care services. Home Health Care Services can assist greatly in this endeavor.

Home Health Care has been defined by the AMA as any arrangement for providing, under medical supervision, needed health care and supportive services to a sick or disabled person in his home surroundings. The provision of nursing care, social work, therapies (such as diet, occupational, physical, psychological, and speech), vocational and social services, and homemaker home health aide services may be included as basic components of home health care. The provision of these needed services to the patient at home constitutes a logical extension of the physician's therapeutic responsibility. At the physician's request and under his medical direction, personnel who provide these Home Health Care Services operate as a team in assessing and developing the home care plan.

In Ohio, there are 102 agencies in 77 of the 88 counties certified to provide such services. Approximately 95 percent of Ohio's population reside in areas where home health service is available.

Just as the patterns of health care delivery are changing, so too is the picture of how the costs of health care will be met. To date, a large portion of the cost of home health service has been met by Medicare and Medicaid. Numerous private insurance companies do offer home care benefits and this promises to continue to increase. Blue Cross of America has developed guidelines for Home Health Care Services Benefit; and currently there are pilot projects under way in Columbus, Youngstown, and Toledo. Most home health agencies will give care beyond the limits of any insurance coverage if the need exists. The family is encouraged to pay the fee, but adjustments will be arranged to meet the family's ability to pay. United Fund and other voluntary monies are often provided to support a portion of the service.

Almost everyone benefits from Home Health Care Services. Patients and families benefit because care is provided in the normalcy of the home environment and the patient can be taught to live in a relatively independent status. The need for some initial admissions, frequent readmissions, and extended stays in institutions can be reduced, thereby benefiting not only the patient but the community by curtailing the amount of needed inpatient facility. The physician benefits, for his efficiency can be increased by a team approach. He can care for a greater

(continued on page 276)

Home Health Care Services *(continued)*

number of patients through a home care program where the services needed by the patient are already assembled and coordinated. Home care staff will implement medical orders, carry out and teach treatment regimens, and offer various supports to the patient and family. In addition, by the home care staff's ongoing intervention to monitor health status, they will be alert to initial signs of impending complications and will often prevent acute crisis and emergency situations from occurring.

The physician should know what Home Health Care Services are available in his community. He should assist in their development and expansion in order that patients might receive such care appropriately, efficiently, and economically.

The physician should utilize the service by referring patients whose needs are best served by home health care. For each patient referred, approval and regular review of a plan of treatment is required. The patient's progress should be regularly reported by the home health staff and updated plans made based upon frequent collaboration. For acute and sudden change in the patient's condition, the home health staff will contact the physician immediately.

Ohio certified home health agencies are listed below by county. The services provided by these agencies are approved by Medicare as of February 1, 1976.

Joya Neff, R.N., Director
Non-Institutional Services
Ohio Department of Health
450 E. Town Street
Columbus, Ohio 43215

ADAMS COUNTY

Adams County Health Department
West Union, OH 45693

ALLEN COUNTY

Lima Visiting Nurses Association
Lima, OH 45801

ASHLAND COUNTY

Ashland County Home Health Service
Ashland, OH 44805

ASHTABULA COUNTY

Home Health Services of
Ashtabula County
Ashtabula, Ohio 44004

ATHENS COUNTY

Mt. St. Mary's Hospital
Nelsonville, OH 45764

AUGLAIZE COUNTY

Auglaize County Nursing Services
Wapakoneta, OH 45895

BELMONT COUNTY

Barnesville Home Health Care Agency
Barnesville, OH 43713
Martins Ferry City Health Dept.
Martins Ferry, OH 43935
Medical Foundation of Bellaire
Bellaire, OH 43906

BROWN COUNTY

U.S. Grant Home Care Unit
Georgetown, OH 45121

BUTLER COUNTY

Butler County Health Department
Hamilton, OH 45011
Hamilton City Health Department
Hamilton, OH 45011
Public Health Nursing Bureau
Middletown, OH 45042

CLARK COUNTY

Community Hospital Home Care
Program
Springfield, OH 45501
Dominican Sisters of the Sick Poor
Springfield, OH 45505

CLINTON COUNTY

Clinton County Health Department
Wilmington, OH 45177

COLUMBIANA COUNTY

Ohio Valley Home Health Services
East Liverpool, OH 43920
Salem Area Visiting Nurses
Association
Salem, OH 44460

COSHOCTON COUNTY

Coshocton City Home Health Agency
Coshocton, OH 43812
Coshocton County Home Health
Service
Coshocton, OH 43812

CRAWFORD COUNTY

Bucyrus City Health Department
Bucyrus, OH 44820

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Galion City Health Department
Galion, OH 44833

CUYAHOGA COUNTY

Cuyahoga County District
Cleveland, OH 44114
Deaconess Hospital Home Care
Cleveland, OH 44109
Home Health Care of Cleveland
Cleveland, OH 44106
Visiting Nurses Assn. of Cleveland
Cleveland, OH 44114

DARKE COUNTY

Darke County Health Department
Greenville, OH 45331

DEFIANCE COUNTY

Defiance County Health Department
Defiance, OH 43512

DELAWARE COUNTY

Delaware City-County Health Dept.
Delaware, OH 43015

ERIE COUNTY

Sandusky City-Erie County
Health Dept.
Sandusky, OH 44870

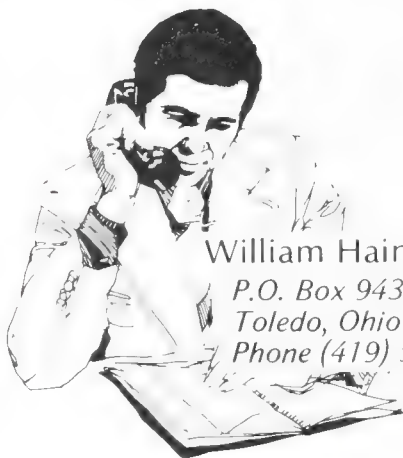
FAYETTE COUNTY

Fayette County Health Department
Washington C.H., OH 43160

FRANKLIN COUNTY

Community Health Nursing Service
Columbus, OH 43215
Dominican Sisters of the Sick Poor
Columbus, OH 43215
Franklin County Board of Health
Columbus, OH 43215

- ALLIA COUNTY**
Gallipolis City Health Department
Gallipolis, OH 45631
Holzer Medical Center
Gallipolis, OH 45631
- EAUGA COUNTY**
Gauga County Health Department
Chardon, OH 44024
- REENE COUNTY**
Greene County Home Care Services
Xenia, OH 45385
- UERNSEY COUNTY**
Guernsey County Gen. Health Dist.
Cambridge, OH 43725
- AMILTON COUNTY**
Cincinnati City Health Dept.
Cincinnati, OH 45229
Lower River Nursing Association
Addyston, OH 45001
Providence Hospital Home Health
Care
Cincinnati, OH 45239
Visiting Nurses Assn. of the Cinn.
Area
Cincinnati, OH 45202
- ANCOCK COUNTY**
Hancock County Home Health
Agency
Findlay, OH 45840
- ARDIN COUNTY**
Hardin County-Kenton City Health
Dept.
Kenton, OH 43326
- ARRISON COUNTY**
Harrison County Health Dept.
Cadiz, OH 43907
- IGHLAND COUNTY**
Highland County Health Dept.
Hillsboro, OH 45133
- OCKING COUNTY**
Mount St. Mary's Hospital
Nelsonville, Ohio
- OLMES COUNTY**
Holmes County Gen. Health Dist.
Millersburg, OH 44654
- URON COUNTY**
Huron County Health Dept.
Norwalk, OH 44857
- ACKSON COUNTY**
Jackson County Health Dept.
Jackson, OH 45640
- FFERSON COUNTY**
Steubenville City Health Dept.
Steubenville, OH 43952
St. John Medical Center
Steubenville, OH 43952
- NOX COUNTY**
Knox County Health Department
Mt. Vernon, OH 43050
Mt. Vernon City Health Dept.
Mt. Vernon, OH 43050
- AKE COUNTY**
Lake County Gen. Health District
Painesville, OH 44077
- AWRENCE COUNTY**
Lawrence County Home Health Care
Ironton, OH 45638
- CKING COUNTY**
Licking County Health Department
Newark, OH 43055
- Newark City Health Department
Newark, OH 43055
- LOGAN COUNTY**
Logan County Gen. Health District
Bellefontaine, OH 43311
- LORAIN COUNTY**
Lorain City Health Department
Lorain, OH 44052
Lorain County Health Department
Elyria, OH 44035
- LUCAS COUNTY**
Lucas County Health Dept.
Toledo, OH 43624
Community Nursing Service
Toledo, OH 43624
- MADISON COUNTY**
Madison County Home Health Care
London, OH 43140
- MAHONING COUNTY**
Visiting Nurses Assn. of Youngstown
Youngstown, OH 44502
- MARION COUNTY**
Marion Co. Home Health Nsrg.
Service
Marion, OH 43302
- MEDINA COUNTY**
Medina County Health Dept.
Medina, OH 44256
- MEIGS COUNTY**
Veteran's Memorial Hospital
Pomeroy, OH 45769
- MERCER COUNTY**
Mercer County-Celina City Health
Dept.
Celina, OH 45822
- MIAMI COUNTY**
Piqua Memorial Hospital
Piqua, OH 45356
- MONTGOMERY COUNTY**
Montgomery County Comb.
General Health District
Dayton, OH 45402
- MORGAN COUNTY**
Morgan County Dept. of Welfare
McConnelsville, OH 43756
- MORROW COUNTY**
Morrow County Health Department
Mt. Gilead, OH 43338
- MUSKINGUM COUNTY**
Zanesville City-Muskingum Co.
General Health District
Zanesville, OH 43701
- NOBLE COUNTY**
Noble County Health Department
Caldwell, OH 43724
- PAULDING COUNTY**
Paulding County Health Dept.
Paulding, OH 45879
- PIKE COUNTY**
Pike County Health Department
Waverly, OH 45690
- PORTAGE COUNTY**
Kent Visiting Nurse Assn., Inc.
Kent, OH 44240
Portage County Comb. Gen. Health
Dist.
Ravenna, OH 44266
Visiting Nurses Assn. of Ravenna
Ravenna, OH 44266
- PREBLE COUNTY**
Preble County Gen. Health Dist.
Eaton, OH 45320
- PUTNAM COUNTY**
Putnam County Gen. Health Dist.
Ottawa, OH 45875
- RICHLAND COUNTY**
Mansfield City-Richland Co.
Health Dept. and Nurses Assn.
Mansfield, OH 44906
Shelby Public Health League
Shelby, OH 44875
- ROSS COUNTY**
Ross County Home Health Agency
Chillicothe, OH 45601
- SANDUSKY COUNTY**
Sandusky Co.-Fremont City Health
Dept.
Fremont, OH 43420
- SCIOTO COUNTY**
Scioto Memorial Hospital
Portsmouth, OH 45662
- SENECA COUNTY**
Seneca County Gen. Health Dist.
Tiffin, OH 44883
- SHELBY COUNTY**
Health Care, Inc.
Sidney, OH 45365
- STARK COUNTY**
Alliance Visiting Nurses Association
Alliance, OH 44601
Visiting Nurses Assn. of Cent. Stark
County
Canton, OH 44703
Visiting Nurses Assn. of W. Stark Co.
Massillon, Ohio 44646
- SUMMIT COUNTY**
Visiting Nurses Serv. of Summit Co.,
Inc.
Akron, OH 44320
- TRUMBULL COUNTY**
Visiting Nurses Assn. of Warren
Warren, OH 44483
- TUSCARAWAS COUNTY**
New Philadelphia City Health Dept.
New Philadelphia, OH 44663
Tuscarawas County Gen. Health Dist.
Dover, OH 44622
- VAN WERT COUNTY**
Van Wert Area Visiting Nurses Assn.
Van Wert, OH 45891
- VINTON COUNTY**
Vinton County Health Department
McArthur, OH 45651
- WARREN COUNTY**
Warren County Gen. Health Dist.
Lebanon, OH 45036
- WASHINGTON COUNTY**
Washington Co. Home Nursg. Services
Marietta, OH 45750
- WAYNE COUNTY**
Wayne County Home Health Agency
Wooster, OH 44691
- WOOD COUNTY**
Wood County Health Department
Bowling Green, OH 43402
- WYANDOT COUNTY**
Wyandot County Home Health
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Legislative Update

David L. Rader, OSMA Associate Executive Director

Legislature Recesses for Spring Primaries

At the end of April, the Legislature held its busiest sessions of the year and then recessed for a five-week time period to allow legislators to campaign prior to the June 8th primary. The Legislature will meet for a three-day period in mid-June and then will recess again for most of the balance of the summer. Skeleton sessions are expected during these time periods but substantive action will probably not be taken.

Physician's Asst. Bill Ready for Governor's Signature

The Ohio Senate passed and sent to the Governor's desk Sub H.B. 663, Hale (D-Columbus), to register physician's assistants through the Ohio State Medical Board. This bill, which has been promoted by OSMA, was not amended during any of the Senate hearings and, therefore, does not need House concurrence before being forwarded for gubernatorial signature. The bill sets stringent requirements for the educational background of physician's assistants, mandates that a physician's assistant must be registered to a given physician or group of physicians, and also states that the registration certificate shall be held by the physician and not by the physician's assistant. It also prohibits the employment of physician's assistants by hospitals and sets standards for revocation of the registration. The OSMA hopes the Medical Board and Ohio physicians can operate under this new law for a while and see what additional changes may be necessary. Language that prohibits the physician's assistant from giving orders to an R.N. or L.P.N. remains a part of the bill, and this may need some clarification later.

Mental Health Bills Receive Concurrence

Two bills that have been of concern to the Ohio State Medical Association to streamline mental patient commitment procedures and to help the Ohio Department of Mental Health and Mental Retardation have passed both Houses and now go to the Governor for signature.

H.B. 1215, Jaskuski (D-Garfield Heights), will allow Timothy Moritz, M.D., Director of the Ohio Department of Mental Health and Mental Retardation, to employ physicians much more freely by removing physicians from the classified civil service. The bill will also permit the Department to sell a number of farm properties to allow for a great deal of capital improvement so the hospitals will meet JCAH standards.

H.B. 244, Leonard (D-Dayton), revises the commitment procedures under which patients may be institutionalized, changes the requirements of probate systems, and creates a legal rights service. OSMA amendments to both these bills have been adopted, and the OSMA's Committee on Mental Health is pleased with the passage of both H.B. 1215 and H.B. 244.

Welfare Director Rejected by Senate

The Senate rejected the Governor's appointment of Raymond McKenna on a strict 21 to 12 party vote. During the floor debate, the majority democrats accused Mr. McKenna of not responding to legislative requests and stated that he was not being a capable administrator. Republicans responded by stating that Mr. McKenna was being made the scapegoat by the Legislature for their own mismanagement of the State budget. No replacement has yet been elected.

Emergency Measure Passed to Expedite Organ Transplants

The lawmakers passed, as an emergency measure, H.B. 1182, Batchelder (R-Medina), which allows a county coroner the right to permit vital organs, especially eyes and kidneys, to be taken from a body for transplantation provided the autopsy can subsequently be performed. The bill would still require adequate prior consent. The bill is the result of an opinion by a prosecuting attorney in Hamilton County which prohibited the coroner in that county from allowing use of these organs in coroner's cases. The bill had the support of the Ohio State Medical Association.

Optometry Bill Remains in Senate Rules

The Ohio Optometric Association now opposes the bill which it originally introduced, **H.B. 432**, R. Hughes (F. Huntsville), to rewrite the Ohio Optometric Practice Act. This bill has been drastically revised since its initial introduction and the optometrists find they no longer can support it. As a result, the bill failed to move out of the Senate Rules Committee and did not receive floor debate during the last hectic week. It is possible the bill may be heard by the full Senate during the June session, however.

Drug Substitution Bill Remains in Committee

The Senate Health & Retirement Committee heard both proponent and opponent testimony on **Sub. S.B. 18**, Freeman (D-Canton), to permit pharmacists to make drug substitutions in some areas and to establish maximum allowable costs for drugs being dispensed to Medicaid recipients. A representative of the OSMA testified in opposition to the concept of the government establishing any type of maximum permissible cost for goods or services and further testified that there are many instances when a physician should be able to expect that the prescription written for a patient should be filled in precisely the manner requested by the physician who, after all, has the ultimate responsibility for the welfare of the patient. Senator Anthony O. Calabrese (D-Cleveland), Chairman of the Committee, indicated there will be no more hearing on this bill in the near future.

Emergency Physician's Liability Restricted

The Ohio Legislature also concurred in **H.B. 832**, Colonna (D-Cleveland), to revamp Ohio's laws concerning emergency medical procedures. This bill will, among other things, limit the emergency room physician's liability for giving advice to paramedics via telemetry. He will still, however, be liable for willful and wanton misconduct. The bill is designed to promote the use of emergency vehicles and equipment in the field with physicians being contacted by radio at a hospital or other base facility. The bill now goes to the Governor for signature.

Patient's Bill of Rights Fails to Pass Committee

The Senate Judiciary Committee chose not to hold any further hearings on **S.B. 363**, Headley (D-Barberton), the "Patient's Bill of Rights." This bill, which has been objected to by the Ohio State Medical Association and the Ohio Hospital Association, probably will not have any further hearings this year. It is very possible, though, that the bill will be revitalized in the next General Assembly.

Podiatry Malpractice Ins. Bill Set for June Debate

Because of the large volume of other bills, the Senate chose to postpone action on **H.B. 1426**, Sweeney (D-Cleveland), to permit podiatrists to be insured under the J.U.A. and to hold debate during the three-day session in June. The Ohio Podiatry Association indicates that insurance will be available until June 30, so the Senate will plan its action to solve this insurance problem before July 1.

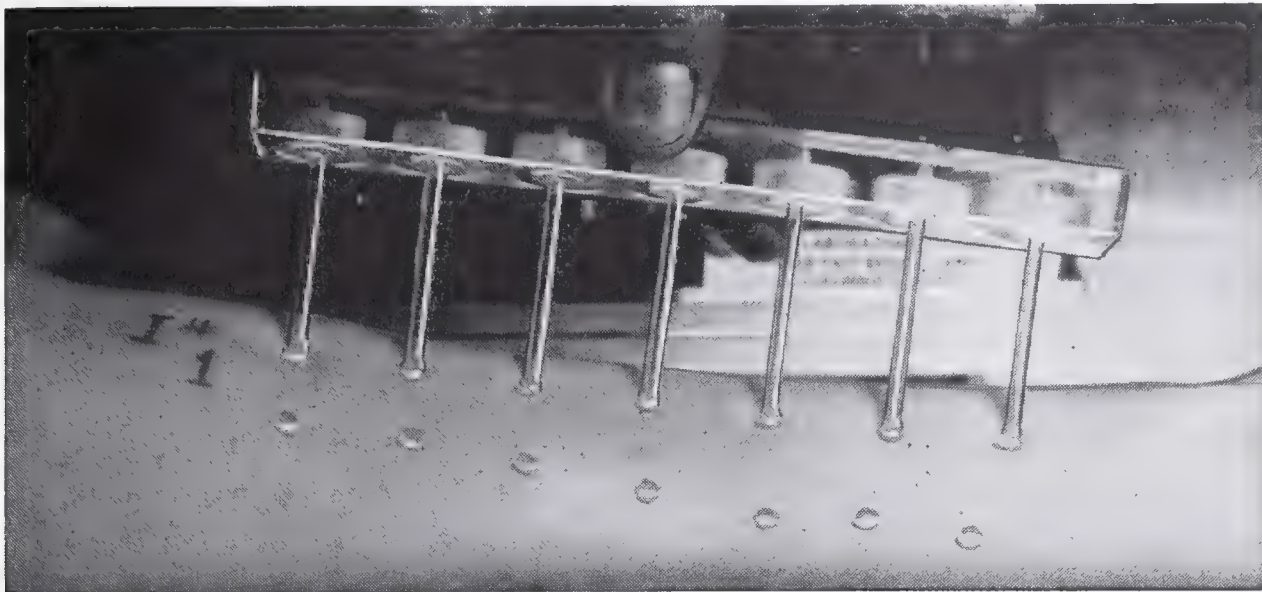
Occupational Therapists to Have Licensing Board

The House agreed to Senate amendments to **H.B. 1227**, Hartley (D-Springfield), to establish an occupational therapy licensing board. This bill establishes occupational therapy as a profession and allows O.T.s to receive third party reimbursement much more easily than they have in the past. In addition, occupational therapists will have established educational standards, and individuals who do not meet these standards will not be permitted to hold themselves out as O.T.s. It is expected that this board will be organized and operating by 1977.

Nonsmoking Areas Bill Passes

In another last-minute effort, the Legislature agreed to **S.B. 96**, Jackson (D-Cleveland), which will require that nonsmoking areas be provided in places of public assembly (50 or more people). The bill, which has been supported by the Ohio Lung Association, is designed especially to work in hospitals and nursing homes. Restaurants, bowling alleys, and taverns are exempted.

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Hepatocellular Adenoma and Oral Contraceptives

Peter A. Ammentorp, M.D.
Robert P. Carson, M.D.

Four cases of benign liver tumor in young women taking oral contraceptives are reported. Three of the tumors were pedunculated. Clinical data from the records of 42 patients reported in U.S., Canadian, and British literature to date are summarized.

ORAL CONTRACEPTIVES are presently being taken by about 50 million women around the world. They are marketed in the United States under approximately 14 trade names. Benign tumors of the liver are being reported with increasing frequency since the first seven cases in which the association with oral contraceptives was suggested by Baum et al, in October 1973.¹ When rupture of the tumor leads to massive intraperitoneal hemorrhage, significant mortality has resulted. We call attention to the possibility of encountering such patients in emergency rooms by reporting four additional cases from a medium-sized community hospital. Package inserts, first dated about July 1975, began to include in the "Warnings" that hepatic lesions, such as those described herein, have been reported in women taking oral contraceptives.

Three of the four tumors described in this article were pedunculated; the fourth protruded from the cap-

sular aspect of the liver. Observations are collected from a review of a total of 42 cases published to date.¹⁻¹⁶

Clinical Findings

A 29-year-old white woman, gravida 7, para 4, had been taking Enovid-E® for eight years. After three attacks of epigastric pain, a mass was found in her right abdomen.

Surgical exploration on November 30, 1970 revealed a nodular mass, 9 cm in diameter, pedunculated from the anteroinferior edge of the right hepatic lobe, abutting on the gallbladder. The mass was excised, along with a 1.5-cm wedge of bordering hepatic tissue. Recovery was uneventful. Repeat liver scan one year later showed a postsurgical defect; however, result of liver scan made almost three years after surgery was normal.

Pathologic examination revealed a well-delineated nodular lesion having the texture of hepatic tissue of a paler yellow color, in contrast to the more usual-appearing border substance. The lesion was well delineated from the adjacent tissue, and an incomplete capsule was evident. Traversing the neoplasm were occasional fibrous trabeculations, along with venous sinuses 2 to 3 mm in diameter. The total specimen weighed 270 gm. Microscopically, the neoplasm consisted of plates and cords of hepatic cells supported by a network of reticulum. These were separated by sinusoid vessels lined by endothelial cells; the appearance resembled mature hepatic architecture without portal areas or bile ducts. Veins, sometimes ectatic, were scattered through the tumor. The individual cells resembled hepatocytes and contained more fat and glycogen than the adjacent liver tissue. Nuclei were slightly larger than those of normal hepatocytes with some variation in size. Double nuclei were seen sometimes, but there was no mitotic activity. There was a pseudocapsule composed of collapsed reticu-

From the departments of internal medicine and pathology, Middletown Hospital, Middletown, Ohio 45204.

Dr. Ammentorp, Middletown, Active Staff, Middletown Hospital.

Dr. Carson, Middletown, Director of Laboratories, Middletown Hospital.

Submitted December 17, 1975.

lum and collagenous framework of the compressed, adjacent, hepatic parenchyma.

A 34-year-old white woman, gravida 3, para 2, had been taking Enovid-E® for six years. She had had a right hemithyroidectomy for mixed follicular and papillary carcinoma of the thyroid in 1962; a right radical neck dissection for metastatic thyroid carcinoma in 1963; and further excision of cervical lymph nodes containing follicular thyroid carcinoma in 1965. On a routine, follow-up examination in November 1970, a mass was found in the right abdomen.

Surgical exploration was undertaken on December 10, 1970. There was a pedunculated mass hanging from the anteroinferior edge of the right hepatic lobe lateral to the gallbladder. The mass was 6.5 cm in diameter and well-delineated. In the pedicle of hepatic tissue was a second nodule 2x1.7 cm in diameter, and a third one 3 mm in diameter. These were within 3 cm of the large nodule, and were included in the resection wedge of 4.7 cm. The cut surfaces of the lesion and the microscopic picture were quite similar to the lesion removed from the 29-year-old patient previously described.

These lesions are considered to be multiple hepatocellular adenomas. Again, the pale yellow color is attributed to increased content of fat and glycogen in comparison to the adjacent liver tissue.

A 24-year-old white woman, gravida 3, para 3, had been taking Oracon® for one year. She presented with a right, upper-abdominal mass after an episode of upper-abdominal pain, vomiting, and diarrhea.

Surgical exploration, January 7, 1972, revealed a tumor mass 9 cm in diameter projecting slightly from the surface of the right hepatic lobe just superior to the gallbladder. It appeared encapsulated, and was paler in color than the surrounding liver. A large wedge was excised from the right hepatic lobe, including the normal gallbladder and a margin of normal tissue. The specimen weighed 240 gm. Within it and bulging from the capsular aspect was a circumscribed mass 6x4.7 cm. Prominent blood vessels traversed the hepatic capsule where it was distended by the neoplasm. There was a gray, incomplete, linear capsular rim; a yellow, serrated outer border about 3 mm in depth; and the central tissue was tan with tinges of grey and pink. Histologically, the pattern was similar to the tumors removed from the two patients previously reported. Color variation was attributed to variations in glycogen and fat, both greater in quantity than in the surrounding normal liver tissue. Again, there were areas with prominent ectatic veins and groups of veins within the depths of the adenoma.

A 28-year-old white woman, gravida 2, para 1, was admitted to the hospital in July 1975 because of the discovery of an abdominal mass. She had been on Ovulen® for 5½ years.

Surgical exploration on July 17, 1975 revealed a nodular mass 10 cm in diameter and pedunculated from

the left lobe of the liver. The mass was excised with 2 cm of bordering hepatic tissue. Its histologic appearance was similar to that of the tumors removed from the first three patients described herein. Recovery was uneventful.

Compilation of Published Cases

The following observations are summarized from descriptions published to date on the 42 cases of hepatocellular adenomas in women taking oral contraceptives, including the four patients described in this article.

Ages varied from 20 to 51 years, with a mean age of 27.3 years. The women had been on the Pill for several years, except for three patients (six months to one year). They presented clinically in several different ways. Almost 40 percent of them were admitted initially with peripheral circulatory collapse and shock, the result of hemoperitoneum. This was due to rupture of a highly vascular tumor or rupture of the overlying hepatic tissue as the tumor expanded.¹⁵ Almost 20 percent presented with epigastric or right, upper-abdominal pain which tended to radiate into the right shoulder. Slightly more than 40 percent of the patients underwent exploratory laparotomy because of a palpable, upper-abdominal mass. A palpable mass also was present in some of the patients who were admitted with pain or who were in shock. The mass was tender in some cases; some pedunculated tumors were remarkably mobile. In one patient, the hepatocellular adenoma was an incidental finding during work-up for an unrelated illness.

Various gastrointestinal complaints (anorexia, nausea, vomiting, and abdominal discomfort) were present for a few days to several months in almost half of the patients. Weight gain or loss, edema, jaundice, chills, fever rarely were present.

Emergency surgery without significant work-up beyond blood counts was the rule in those admitted with shock. When investigation was more extensive, selective hepatic angiography was the most reliable procedure. The result was positive in all 11 cases in which it was done.

Radiographic examination of the gastrointestinal tract rarely was helpful, except for the barium enema which showed displacement of a section of the colon in about half the cases. Liver scan revealed a filling defect in only two-thirds of the patients. Peritoneoscopy was not used on any patient.

Exploratory laparotomy revealed a single mass in 87 percent and multiple masses in 13 percent of the patients. Two thirds of the single tumors were located in the right lobe, one third in the left lobe, and one was in the quadrate lobe. Two of the patients who exhibited multiple nodules had involvement of both the right and left lobes.

A pedunculated tumor was found in five patients. The attachment was to the right lobe in two of these and to the left lobe in three. It is remarkable that three of the four tumors reported in this article were of the pedunculated type.

ated variety, and the fourth was projecting from the hepatic surface.

Treatment consisted of excision when feasible. This required right or left hepatic lobectomy in 20 cases (48 percent). In the remainder, the tumor was excised with a rim of normal liver, except for five cases (12 percent) in which a part or all of the adenomatous tissue was left behind. The outcome was fatal in eight cases (19 percent) including one patient whose condition was erroneously diagnosed as acute cholecystitis. She died at home about three hours later.² Three patients were reported to have died "immediately from hemorrhage,"¹⁰ and three died from problems of hemostasis following right, hepatic lobectomy.^{1,3,4} One patient had been on hemodialysis for many years and was taking large doses of oral contraceptives (up to three tablets daily) for persistent menorrhagia. Surgical intervention was unsuccessful because the liver contained multiple, discrete, highly vascularized tumors.¹⁶ Complications in patients who survived surgery included serious coagulopathy, transient hepatic insufficiency of variable duration, and infection, sometimes in the form of subphrenic abscess.^{1,13}

Discussion

Benign liver tumors constitute a new and rare complication probably associated with the use of oral contraceptives. A causal relationship has previously been accepted between progestin-estrogen combinations and the increased occurrence of thrombophlebitis, pulmonary embolism, cerebral thrombosis and hemorrhage, thrombosis of the hepatic veins (Budd-Chiari syndrome), decreased glucose tolerance, hypertension, gallbladder disease, and porphyria cutanea tarda symptomatica.¹⁷ A recent case of thrombosis in the hepatic veins within the liver leading to rupture of the liver with hemoperitoneum has been reported.¹⁸

Pathologic appearance of these benign liver tumors indicates they are of a single variety. Hepatocellular adenoma is the most commonly used designation,^{19,20} and it seems appropriate. Focal nodular hyperplasia, regenerative nodules and hamartomas may be confused with this lesion, but distinctive identifying characteristics should be evident. Furthermore, there apparently has been no recent increase in the incidence of these other lesions, particularly nodular hyperplasia which may occur in infants and children. It was not an uncommon pathologic finding before the introduction of oral contraceptives.¹⁹ Recently, a few cases of malignant tumors have been found,^{20,21} but their occurrence in women taking oral contraceptives may be fortuitous. There has been an unquestionable, dramatic increase in the incidence of the hepatocellular adenomas in the past 10 years. Various estimates range from 1:500,000 to 1:1,000,000 women taking oral contraceptives.²⁰

Despite the increasing number of reports of liver tumors associated with patients using oral contraceptives,

clear-cut evidence of etiologic relationship of oral contraceptives to hepatocellular adenoma has not been established. This relationship cannot be proved on the basis of clinical reports of a small, or even a large, number of patients. Experimentally produced morphologic and chemical changes have been sought but remain inconclusive.²¹⁻²³ Although no one disputes the recent increase in incidence of this heretofore extremely uncommon tumor, the rarity of hepatocellular adenoma before and after introduction of oral contraceptives (in 1960) makes it unlikely that even large-scale prospective studies with appropriate controls will yield convincing results. However, the Armed Forces Institute of Pathology has more than 75 cases on file, and an epidemiologic survey of these patients is underway.¹⁹ The most convincing evidence of etiologic association will be available when more cases are collected in which regression of adenomas or parts of adenomas, which were left in the liver for some reason or other, can be shown as taking place after the discontinuance of the oral contraceptive. Unfortunately, at present, the risk of hemorrhage makes it imprudent to deprive the patient of resection of the adenoma but, in several cases, resection was impossible.^{7,11-14} Follow-up of such cases may furnish the answer. Liver scan made 20 months later on one of these patients¹³ and liver scan plus hepatic arteriography on another¹² have shown no tumor or defect following discontinuation of the oral contraceptive medication.

In patients presenting with the combination of right, upper-abdominal pain, and shock, the initial impression may be of apparent pancreatitis, perforated duodenal ulcer, appendicitis, or cholecystitis. Abdominal paracentesis establishes the presence of hemoperitoneum. Ectopic pregnancy and ruptured corpus luteum are excluded on the basis of the contraceptive medication. Emergency laparotomy is always indicated. Patients with or without gastrointestinal complaints and abdominal mass undergo an elective work-up. The differential diagnosis includes ovarian and mesenteric cysts and even (as in one of our cases of pedunculated adenomas) splenomegaly. Hepatic angiography was the most revealing procedure, the result being positive in all patients in whom it was employed preoperatively. Result of liver scan alone was positive in only two-thirds of the patients in whom it was done. Results of gastrointestinal x-ray series are not too specific as they reveal only displacement or distortion of various segments, most frequently the right-sided colon. Liver function tests usually are normal, and α^1 fetoproteins and hepatitis-B surface antigen are negative. If hepatic angiography is unavailable, combined use of liver scan and peritoneoscopy has been reported to yield only 7 percent false negative and no false positive results in large series of liver tumors of various types.²⁴

Treatment has consisted of resection when technically feasible. This was relatively easy in the three patients with pedunculated adenoma described herein, but it often requires hepatic lobectomy with subsequent transient coagulopathy and hepatic insufficiency. In patients where complete removal of all adenomatous tissue is

impossible, hopefully, regression of the nodules will occur when the exogenous hormonal influence ceases.¹³ In any event, the oral contraceptive therapy is always discontinued in proven cases. However, the apparent low incidence of these tumors in the total population using these agents is no indication for discontinuing their use at the present time.¹³

Acknowledgements: John W. Barnes, M.D.; David M. Gerber, M.D.; James L. Sawyer, M.D.; and Gilbert P. Wagoner, M.D., supplied some of the clinical data concerning the four patients reported in this article. Records of these four cases were accepted for the files of the Armed Forces Institute of Pathology, and concurrence with the diagnosis was assured in each case.

Generic and Trade Names of Drugs

Norethynodrel with mestranol—Enovid-E (Searle)
Ethinyl estradiol and dimethisterone—Oracon (Mead Johnson)
Ethinodiol diacetate with mestranol—Ovulen (Searle)

References

1. Baum JK, Bookstein JJ, Holtz F, et al: Possible association between benign hepatomas and oral contraceptives. *Lancet* 2:926-929, 1973.
2. Contoslavlos DL: Letters: Benign hepatomas and oral contraceptives. *Lancet* 2:1200, 1973.
3. Knapp WA, Ruebner BH: Letters: Hepatomas and oral contraceptives. *Lancet* 1:270-271, 1974.
4. Kelso DR: Letters: Benign hepatomas and oral contraceptives. *Lancet* 1:315-316, 1974.
5. Horvath E, Kovacs K, Ross RC: Ultrastructural findings in a well-differentiated hepatoma. *Digestion* 7:74-82, 1972.
6. O'Sullivan JP, Wilding RP: Liver hamartomas in patients on oral contraceptives. *Br Med J* 3:7-10, 1974.
7. Kay S, Schatzki PF: Ultrastructure of a benign liver cell adenoma. *Cancer* 28:755-762, 1971.
8. Mays ET, Christopherson WM, Barrows GH: Focal nodular

hyperplasia of the liver. Possible relationship to oral contraceptives. *Am J Clin Pathol* 61:735-746, 1974.
9. Tountas C, Paraskevas G, Deligeorgi H: Letters: Benign hepatoma and oral contraceptives. *Lancet* 1:1351-1352, 1974.
10. Berg JW, Ketelaar RJ, Rose EF, et al: Letters: Hepatomas and oral contraceptives. *Lancet* 2:349-350, 1974.
11. Stauffer JQ, Lapinski MW, Honold DJ, et al: Focal nodular hyperplasia of the liver and intrahepatic hemorrhage in young women on oral contraceptives. *Ann Intern Med* 83:301-306, 1975.
12. Model DG, Fox JA, Jones RW: Letters: Multiple hepatic adenomas associated with an oral contraceptive. *Lancet* 1:865, 1975.
13. Ameriks JA, Thompson NW, Frey CF, et al: Hepatic cell adenomas, spontaneous liver rupture, and oral contraceptives. *Arch Surg* 110:548-557, 1974.
14. Antoniadis K, Brooks CE: Hemoperitoneum from liver cell adenoma in a patient on oral contraceptives. *Surgery* 77:137-139, 1975.
15. Hermann RE, David TE: Spontaneous rupture of the liver caused by hepatomas. *Surgery* 74:715-719, 1973.
16. Vosnides G, O'Keeffe B, Brander W, et al: Letters: Liver hamartomas in patients on oral contraceptives. *Br Med J* 3:580, 1974.
17. Elder GH, Magnus IA: Letters: Oral contraceptives and the liver. *Br Med J* 1:37, 1975.
18. Frederick WC, Howard RG, Spatola S: Spontaneous rupture of the liver in patient using contraceptive pills. *Arch Surg* 108:93-95, 1974.
19. Ishak KG, Rabin L: Benign tumors of the liver. *Med Clin North Am* 59:995-1013, 1975.
20. Baum JK: Letters: Liver tumors and oral contraceptives. *JAMA* 232:1329, 1975.
21. Medical News: A few women taking the pill found to have benign liver tumors. *JAMA* 231:451-452, 1975.
22. Lingeman CH: Letters: Liver-cell neoplasms and oral contraceptives. *Lancet* 1:64, 1974.
23. Beaconsfield P: Letters: Liver tumours and steroid hormones. *Lancet* 1:516-517, 1974.
24. Sauer R, Fahrlander H, Fridrich R: Comparison of the accuracy of liver scans and peritoneoscopy in benign and malignant primary and metastatic tumours of the liver. *Scand J Gastroenterol* 8:389-394, 1973.



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Trichobezoar

Lesley L. Walls, M.D.

Trichobezoar is a very uncommon disorder. It is an entity seen most commonly in young females and always with accompanying psychologic and emotional problems. Complications include upper-gastrointestinal obstruction, gastric ulceration with bleeding, macrocytic or microcytic anemia, protein-losing enteropathy, perforation of the stomach with peritonitis and death.

TRICHOBEZOAR IS A VERY uncommon disorder.

It usually is seen in young females since they tend to have longer hair which predisposes to accumulation in the stomach when ingested. According to Bockus,¹ approximately 90 percent of trichobezoar cases are females under the age of 30 years; and all such cases have manifested psychiatric problems ranging from chronic anxiety to severe mental retardation. Trichobezoar is a symptom of an underlying psychiatric disorder and not a disease entity in itself. The primary care physician plays an important role in the diagnosis and coordination of the team management of this disorder since surgical treatment is mandatory and deep-rooted psychologic problems requiring psychologic evaluation often are present. Treatment by a psychiatrist is needed in many instances; however, outpatient counseling by the family physician may be sufficient.

In 1939, DeBakey and Ochsner² reviewed 311 bezoar cases and listed the following statistics which are cited in recent literature pertaining to bezoar:

1. Presenting symptoms consist of upper gastric pain in 75 percent of the cases, and periodic nausea and vomiting in 65 percent of cases.
2. Less common presenting symptoms are weight loss, malaise, anorexia, diarrhea, and melena.
3. Almost 90 percent of trichobezoars are palpable in the midepigastrium and left, upper quadrant at presen-

tation, and this usually initiates hospitalization for evaluation.

Admitting diagnosis seldom includes bezoar in the differential, but it usually contains blood dyscrasia, gastric neoplasm, hepatic tumors, renal tumors, pancreatic pseudocyst, and splenic enlargement of uncertain etiology. An x-ray film of the abdomen and an upper gastrointestinal series usually will indicate a diagnosis of trichobezoar even in the absence of a history of hair ingestion.^{3,4}

Complications include total, upper-gastrointestinal obstruction, gastric ulceration and hemorrhage, gastric perforation with peritonitis, and even death.^{1,4-6} Macrocytic anemia may occur on the basis of dietary intake as well as a result of infection within the bezoars, similar to a blind loop syndrome. Hypochromic microcytic anemia may result from chronic, gastrointestinal blood loss associated with the gastric ulceration. The association of gastric polyps and trichobezoars is well documented⁵ but is very uncommon; however, a protein-losing enteropathy and steatorrhea may occur when these are present.

The current treatment for trichobezoar is surgical removal. DeBakey and Ochsner's statistics show a 72 percent mortality rate from unoperated trichobezoars versus a 4 percent mortality rate with operative removal. The mortality rate approaches 100 percent in cases with perforation and peritonitis. It is well known that phytobezoar associated with ulcer operations can be dissolved by using Mucomyst® or Adolph™ meat tenderizer (papain); however, trichobezoars cannot be safely dissolved in the stomach.

The literature contains documented cases of multiple operations for removal of trichobezoars recurring from continued hair ingestion after removal of the first trichobezoars.^{1,6,7}

Clinical Data

A 10-year-old girl presented to our office in July 1974 complaining of a tender mass in her abdomen. She had noticed the mass one week prior to the office visit and had complained to her mother. Due to her persistent complaining, her mother brought her to be examined.

During the interview, her mother also expressed concern because the child had been vomiting solids inter-

mittently after meals and her hair had been "falling out" for three or four months. There was no history of weight loss; the child had been tolerating liquids well; and there was no other gastrointestinal symptomatology. As the hair loss was diffuse, the mother had been trimming the longer hair to make the loss less obvious (Figs. 1 and 2).

The remainder of the review of systems was negative. The child had always been very healthy, was an excellent student, and was involved in many extracurricular activities. On examination, she appeared very thin, uncomfortable, and obviously very anxious. Physical findings included diffuse hair loss with abundant new hair growth, very short fingernails from chronic nail biting, and a 10-cm, solid, rock-hard mass in the left, upper-quadrant midepigastrium, moderately tender to palpitation.

She was admitted to the hospital for evaluation of the abdominal mass. Admitting diagnosis was splenomegaly; rule out lymphoma. X-ray films of the abdomen and serum blood count were ordered promptly on arrival. The complete blood count was totally unremarkable; x-ray film of the abdomen revealed a large mass which appeared to be in the stomach (Fig. 3). The patient was questioned at that time about ingesting her hair, but she adamantly denied it. However, enroute to the radiology department for an upper-gastrointestinal series, she admitted that she had been eating her hair for approximately six months and had only recently stopped.

Results of the upper-gastrointestinal series confirmed a mass consistent with trichobezoar (Figs. 4 and 5).

As a trichobezoar cannot be treated medically, surgical consultation was obtained. She underwent operative removal of the bezoar, had a completely benign post-

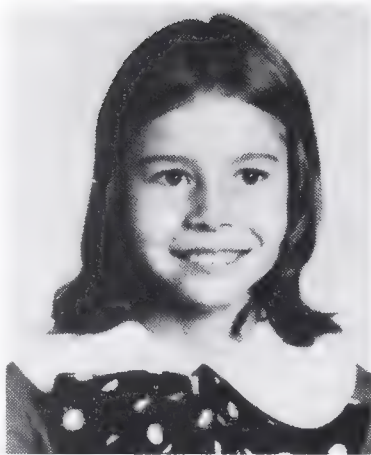


FIG. 1 (left). Photograph of patient made less than one year prior to initial office. FIG. 2 (right). Appearance at time of initial office visit.

operative course, and was discharged on the fifth postoperative day (Figs. 6 and 7).

As an outpatient, the child underwent psychiatric evaluation including a battery of psychologic tests. These revealed an anxious girl with a high need for achievement. Her full-scale IQ was 121, verbal 131, and performance 105. She showed a poor relationship with her father, and was very dependent on her mother. Both parents were evaluated as outpatients; each was thought to be depressed and very dependent. The parents were offered therapy, but refused.

Overall prognosis for the patient was considered good because she was very intelligent and realized the consequences of hair ingestion. She responded very well to outpatient counseling in the family practice office. On

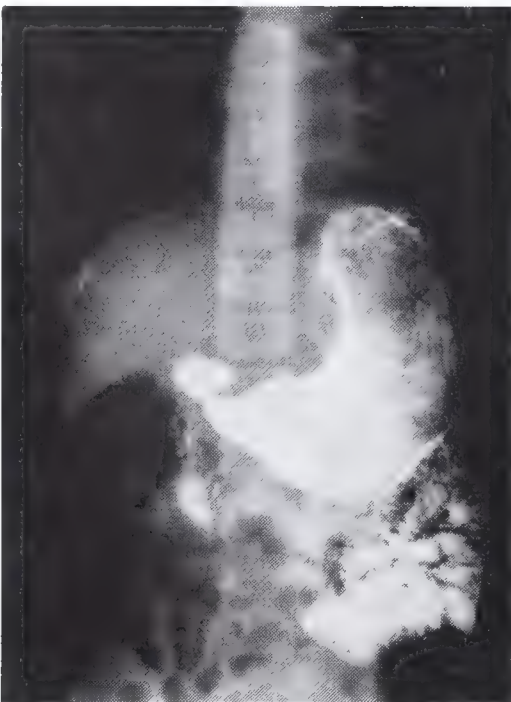
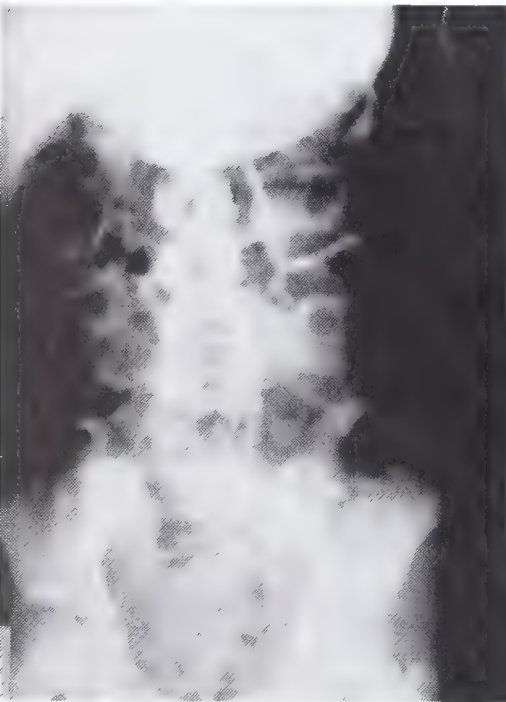


FIG. 3 (left). X-ray film of abdomen showing mass in stomach. FIG. 4 (center). X-ray film showing mass as revealed on upper-gastrointestinal series. FIG. 5 (right). X-ray film made three hours after beginning of upper-gastrointestinal series showing mass and remainder of barium in ascending colon.



FIG. 6 (left). Trichobezoar at time of operative removal.
FIG. 7 (right). Trichobezoar after removal (dimensions 10 X 20 cm).

ear after surgery, she continues to manifest mild anxiety, but she apparently is not ingesting her hair (Fig. 8) although she continues to twirl and pull at it and to bite her nails.

Summary

Trichobezoar is not a common entity, but must be considered in the differential diagnosis of an upper-quadrant, abdominal mass, especially in the presence of manifestations of anxiety, mental retardation, or other psychologic and emotional disorders. Presenting symptoms are epigastric pain in 70 percent of the cases, nausea and vomiting in 65 percent of the cases, and less commonly, weight loss, malaise, anorexia, melena, and diarrhea. Psychologic symptoms always are present, however, these may be masked by an intelligent patient. Examination on admission will reveal a palpable mass in the midepigastrium and left, upper quadrant in 90 percent of the cases. Evidence of hair loss usually is present, but not always; evidence of psychologic problems always is present, if properly evaluated. Ninety percent of the cases are females with long hair. Complications include upper-



FIG. 8. Photograph of patient made 10 months post-operative showing regrowth of hair.

gastrointestinal obstruction, gastric ulceration and bleeding, perforation leading to peritonitis, macrocytic or microcytic anemia, gastric polyposis, protein-losing enteropathy and steatorrhea, and even death.

Generic and Trade Name of Drug

Acetylcysteine—Mucomyst (Mead Johnson)

References

1. Bockus H: *Gastroenterology* (ed 3), Philadelphia, WB Saunders, 1974.
2. DeBakey M, Ochsner A: Bezoars and concretions. A comprehensive review of the literature with an analysis of 303 collected cases and a presentation of 8 additional cases. *Surgery* 4:934-963, 1938 and 5:132-160, 1939.
3. Gwinn JL, Barnes GR Jr: Radiological case of the month: posterior urethral valve with bilateral ureteral reflux. *Am J Dis Child* 113:273-274, 1967.
4. Small A, Muehlbauer M, Kleinhaus S: Obstructing giant trichobezoar involving stomach and duodenal bulb. *Am J Gastroent* 50:297-302, 1968.
5. Hossenbocus A, Colin-Jones DG: Trichobezoar, gastric polyposis, protein-losing gastroenteropathy and steatorrhea. *Gut* 14:730-732, 1973.
6. Pandeya NK: Trichobezoar: case presentation and review of literature. *J Am Osteopath Assoc* 72:628-634, 1973.
7. Savage WM, Inglesias OE: Trichobezoar. *J Ky Med Assoc* 69:927-969, 1971.

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Testing in Humans: Who, Where & When.

The weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential

status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.



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Simple Transcrotal Orchiectomy

Phillip F. Nasrallah, M.D.
Jack L. Summers, M.D.
Manley L. Ford, M.D.

An efficient method of bilateral orchiectomy for ablative therapy in carcinoma of the prostate is described. One hundred of such cases at Akron City Hospital from 1970 through 1973 are reviewed. This description is offered as a reference for urologists in training and for those urologists who have not seen this procedure illustrated.

SINCE 1941, when Huggins and Hodges reported the efficacy of hormonal manipulation in the treatment of prostatic carcinoma,¹ orchiectomy has been a widely used urologic tool in the management of this disease. The technique for bilateral orchiectomy commonly described is the bilateral inguinal approach in which the cord is divided just below the external inguinal ring.² A transcrotal approach through the median raphe has been described for subcapsular orchiectomy, but the subcapsular methods have been abandoned as a means of ablative therapy.³ An alternative technique of bilateral scrotal incisions has been described and widely used.^{4,5}

In our hospital, a transverse, transcrotal-dependent approach is the method used exclusively. We do not pretend to be the originators of this method. However, since orchiectomy is such an important part of the urologist's armamentarium against prostatic carcinoma, we feel a description of the technique is warranted.

Methods and Materials

Between January 1, 1970 and December 31, 1973, there were 428 patients admitted to Akron City Hospital with a diagnosis of carcinoma of the prostate. Of these, 100 subsequently underwent bilateral orchiectomy for palliation of advanced disease. All patients had tissue-proven disease—chemically (acid phosphatase), radiographically (scan or skeletal survey), or by biopsy. The technique is as follows:

The patient is placed in the supine position, is given a local or a general anesthesia, the scrotum is prepared

with Betadine Surgical Scrub,[®] and routinely draped. With the surgeon to the patient's right, the scrotum is grasped with the left hand and the contents forced against the inferior wall of the sac (Fig. 1). While constant pressure is applied with the left hand, a transverse incision, 4 to 6 cm long (Fig. 2), is made through the skin and tunica layers down to the tunica vaginalis; the testis with its covering tunica vaginalis can be easily expressed from the wound. The tunics are then wiped cephalad with a



FIG. 1. Scrotum is grasped by left hand and contents are forced against inferior wall of sac.

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Submitted October 17, 1975.



FIG. 2. Transverse incision through skin and tunic layers.

dry gauze square. The dissection is easiest if the vaginalis is not opened. The cord can be stripped as high as desired (Fig. 3). The cord is divided into three segments (one being the isolated vas) between hemostats, and the proximal ends are suture-ligated with 2-0 chromic suture ligature and circular-free ties of 2-0 chromic suture placed proximally to the suture ligature. The corners of the incision are grasped with forceps, and the stretched incision is closed in two layers with interrupted 4-0 chromic catgut. No drain is needed because of the thorough and controlled suture ligation of the vessels and vas deferens.

Discussion

In the period from 1970 through 1973, we had no complication of orchiectomy attributable to the incision.

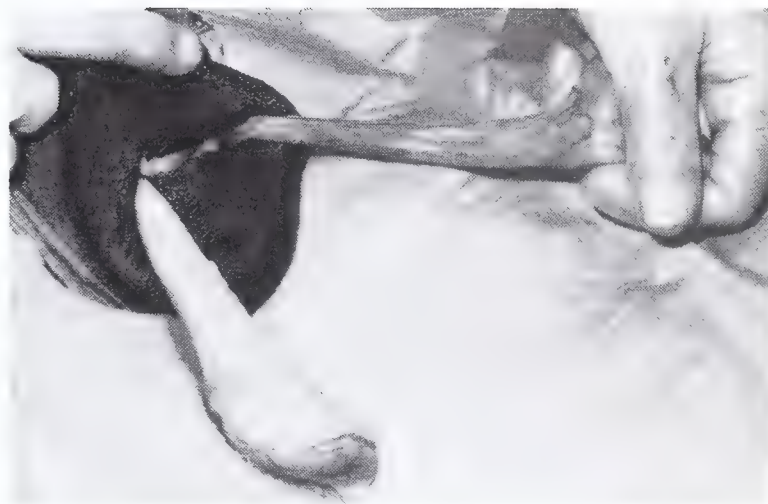


FIG. 3. Cord is stripped to desired height.

Of 100 cases, there has been no hematoma, wound infection, or surgical complication. The advantage of a single, relatively painless incision over the more painful double-inguinal or scrotal incisions is obvious. The transcrotal procedure also is much faster—an important consideration in the elderly debilitated patient. A tissue drain is not needed. Finally, the incision is closed with absorbable suture, and this shortens the period of postoperative hospitalization.

Summary

An efficient method of bilateral orchiectomy for ablative therapy in carcinoma of the prostate has been described. Of 100 patients who underwent this procedure in the period from 1970 through 1973, there has been no hematoma, wound infection, or surgical complication.

Generic and Trade Name of Drug

Povidone-iodine—Betadine Surgical Scrub (Purdue Frederick Co.)

References

1. Huggins C, Stevens RE, Hodges CV: Studies on prostatic cancer: II. the effects of castration on advanced carcinoma of the prostate gland. *Arch Surg* 43:209-223, 1941.
2. MacDonald SA: Orchiectomy for carcinoma of prostate, in Campbell MF, Harrison JH (eds): *Urology*, ed 3, Philadelphia, Saunders, 1970, vol 3, pp 2659-2660.
3. Winsbury-White HP (ed): *Textbook of Genito-Urinary Surgery*, ed 2, Baltimore, Williams & Wilkins, 1961, p 632.
4. Flocks RH, Culp D: *Surgical Urology*, ed 2, Chicago, Year Book, 1963, p 432.
5. Dodson, Austin I: *Urological Surgery*, ed 2, St. Louis, Mosby, 1950, p 539.

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Retention of Medical Records

(Editor's Note: The following material is a letter from James E. Pohlman, J.D., OSMA Legal Counsel, to Hart F. Page, OSMA Executive Director, on the question of medical records.)

You have asked for our opinion as to the length of time physicians should retain patient records after the physician-patient relationship is terminated either voluntarily by the patient or by the death or retirement of the physician. (It is assumed, of course, that where the physician-patient relationship is active the physician will maintain all records generated by the relationship regardless of its duration.) You have furnished us with the materials gathered by the Medical Association over the years as a reference point, and we have attempted to update and incorporate that material into this opinion.

First of all, legislation in several different contexts bears directly on the issue of the length of time physicians' records should be maintained. The most striking change in the whole area of timing occurred with the enactment of Amended Substitute House Bill No. 682, effective July 28, 1975. Particularly pertinent is the Amendment to Section 2305.11 of the Ohio Revised Code which sets the statute of limitations for a malpractice action against a physician or a hospital at one year. Further, however, Section 2305.11(B) provides as follows:

In no event shall any medical claim against the physician or hospital be brought more than four years after the act or omission constituting the alleged malpractice occurred. The limitations in this section for filing such a malpractice action against the physician or hospital apply to all persons regardless of legal disability and notwithstanding Section 2305.16 of the Revised Code, provided that a minor who has not attained his tenth birthday shall have until his fourteenth birthday in which to file an action for malpractice against a physician or hospital.

Thus, for purposes of record maintenance, a patient's records should be kept a minimum of four years from the date of service except in those cases where a minor under the age of ten years has been treated, in which case the records should be kept until the patient attains the age of fourteen. Of course, conceivably this time period could be so much as fourteen years in a given case involving a minor. [It should also be noted that the four-year limitation contained in R. C. Sec. 2305.11 (B) applies to the "foreign body" cases subject to the "discovery" rule, so that protection is afforded to the doctor even in the "foreign body" cases.]

Another statute of limitations, unchanged by House Bill 682, is the statute limiting the time in which to bring an action for wrongful death (Section 2125.02). This statute of limitations continues to be two years.

At this point two other items raised deserve comment. First, the indication in one journal article studied indicates that an action for fraud against a physician should be considered. We would certainly emphasize that such an action is unlikely; but, in any event, the statute of limitations for such fraud is four years within Section 2305.09. Second, the point is raised concerning a counterclaim by a patient against a doctor wherein the original claim is filed by the physician to collect a bill. Research of the law indicates that the filing of a lawsuit for collec-

tion of a debt does not waive the defense of the statute of limitations to the patient's counterclaim based on any alleged malpractice.

Consideration should also be given to the Workmen's Compensation statutes dealing with the continuing jurisdiction of the Industrial Commission to adjust a Workmen's Compensation claim. The statute in question is Section 4123.52 of the Revised Code. That statute gives the Industrial Commission discretion to modify or change any aspect of its findings or orders in a particular matter where justified. The length of time in which such discretion may be exercised depends on the kind of disability and compensation benefits paid for the particular injury or disease. In many cases, however, the Industrial Commission has discretion to modify or change its orders within ten years of the date of the last payment of compensation, or from the date of the claimant's death. The ramifications of this discretionary statute quite obviously place Workmen's Compensation cases within those situations which would warrant the maintenance of physicians' records for an indefinite period of time in a particular case. Nonetheless, no statute in this context mandates this record maintenance by the physician.

One further statutory scheme must be considered in deciding the appropriate length of time to maintain physicians' records. Physicians as dispensers and prescribers of drugs of various types are subject to both federal and state laws regarding the record keeping on the dispensing of these drugs. Statutes requiring the physician to maintain records of the administration of certain drugs are Section 3719.07 of the Ohio Revised Code and 21 U.S.C. Section 827. Both of these statutes and other drug abuse control laws provide for the maintenance of such records for a period of two years.

(continued on page 296)

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Medical Records *(continued)*

Other aspects of record maintenance should be considered. First, in the sale of a medical practice it must be understood that the patient's records, and treatment aids such as x-rays, are the property of the physician and not the patient (absent an agreement to the contrary). Written authorization should be obtained from the patient to transfer medical records to another physician, and the patient should direct the physician to so transfer those records. We would recommend the adherence to the guidelines of the AMA publication furnished to us by your office in which it is recommended that those records of patients who do not authorize the transfer to the purchasing physician be retained for the duration of the pertinent statute of limitations to protect the selling physician or his estate should a malpractice claim arise thereafter.

The death of a physician presents another situation. A representative of the deceased physician is within his rights to destroy whatever records he has on file if he so chooses. Probably the more acceptable practice is to turn over the records to a reputable physician. We can find no duty on behalf of the legal representative of a deceased physician to maintain the records of the patient following the death of the physician. However, we would certainly feel that it would be in the best interests of both the estate and of the patients to make arrangements for the dispensing of the records and notification to the patient as we have described.

The final point deserving comment is the simple matter of discretion to be exercised by the physician as to

the keeping of records in the relationship of physician and patient. We see no reason to dispute the logic of the AMA publications which recommend a discretionary maintenance for a period of six to ten years. This discretion arises in the context of a patient who ceases to be actively treated by the particular physician, but quite likely would request medical information after the cessation of treatment.

Thus, in summary, it would appear that two particular situations arise for maintenance of records by a physician beyond the suggested six to ten year discretionary period. First, the situation of the malpractice statute of limitations in the context of treatment of an infant presents special concern because of the potential for a fourteen-year statute of limitations applicable to the bringing of a malpractice action regarding such an infant. Second, the problem with the continuing jurisdiction of the Industrial Commission in Workmen's Compensation cases exists making it very difficult to predict the proper time period for maintaining records in the Workmen's Compensation situation. We would simply suggest that in the case of the treatment of an infant and in the case of the treatment of a person whose history indicates that the disease or injury was work-related (or in which a Workmen's Compensation claim is made), that special note of these situations be made and the appropriate record keeping conducted.

We intend this to be a summary treatment of the various considerations at issue in record maintenance decisions. We would be happy to expand upon any of the points related in this summary. If such a clarification is desired, please let us know.

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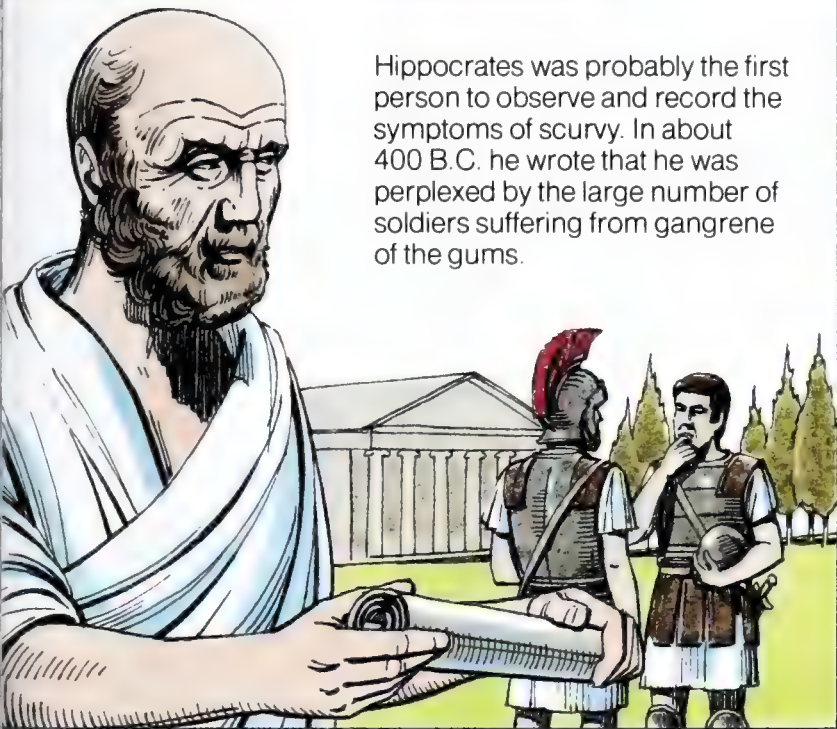
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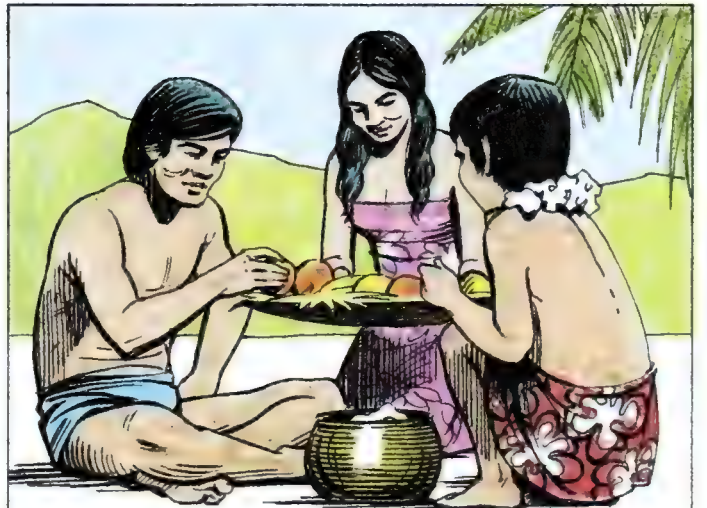
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The **ALLBEE with C** Scrapbook of Vitamin Facts & Fallacies

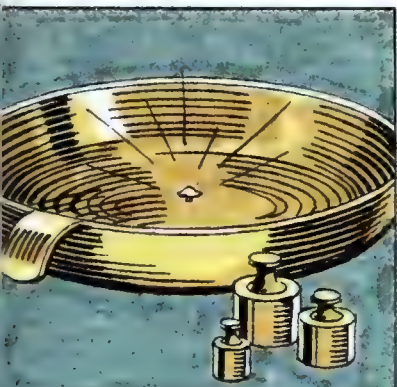
Northern and Central Europeans must obtain their vitamin C primarily from cabbage because these countries don't have a Florida or California as a source of citrus fruits. These inhabitants get about twice as much ascorbic acid when they eat their cabbage raw as when they boil it.



Hippocrates was probably the first person to observe and record the symptoms of scurvy. In about 400 B.C. he wrote that he was perplexed by the large number of soldiers suffering from gangrene of the gums.



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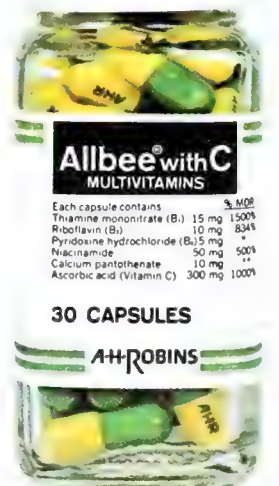


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A Profile for Progress: John H. Budd, M.D.

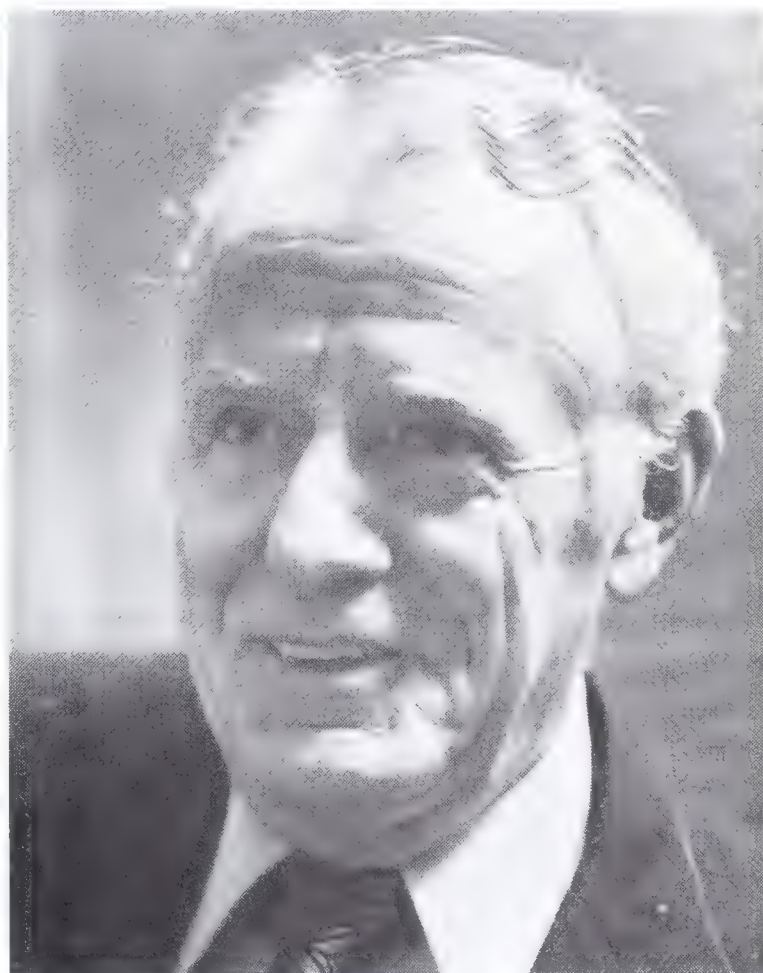
Ohio's Candidate for AMA President-Elect

Ohio enthusiastically offers the AMA a man of experience in John H. Budd, M.D., candidate for AMA President-Elect. Dr. Budd is a member of the AMA Board of Trustees on which he has served for six years. In addition, he is the Secretary-Treasurer of the organization and Secretary of the Board of Trustees.

Dr. Budd has been interested in the advancement of the health care profession in the United States since his youth. He wrote in the *Dalhousie Yearbook* during his years as a senior medical student at Dalhousie University:

While the science of healing has made tremendous strides, the business of healing has rather lagged behind. In the years to come there will probably be increasing dissatisfaction with the organization of medical service. Something will have to be done to divide the cost of care more evenly. In some places we already see a change, and the drift is very often towards state medicine. The majority of our doctors look upon this solution with disfavor. Now is the time for medical men to consider these matters. If they fail to find a solution, the people or the government may find one which will be very unsatisfactory to the profession.

Since graduation from Dalhousie, Dr. Budd has become increasingly involved in both the active, clinical practice of medicine and the socio-economic problems of the profession. He has contributed ten years of service as an AMA Delegate from Ohio followed by six years of diligence on the AMA Board of Trustees. His involvement culminates in his desire to contribute his talents to the office of AMA President-Elect.



John H. Budd, M.D., is a man of principle and conviction. He is his own man: one who weighs alternatives and makes decisions based on fact.

During his years on the Board of Trustees, Dr. Budd has participated in numerous areas of advancement of the profession. He is an AMA Commissioner on the Joint Commission on Accreditation of Hospitals and Chairman of the Commission's Standards and Survey Procedures Committee. He stresses that this committee must provide flexibility in the rules of the Joint Commission because situations vary across the country due to size, location, and type of hospitals.

"Our mission," said Dr. Budd, "is to improve the quality of care."

Dr. Budd is also Chairman of the AMA Board of Trustees Committee on Organization and Operation of the Board which reviews how the Board functions. In addition, he serves on the Nominating Committee of the Board.

(continued on page 300)



Left to right: John H. Budd, M.D., chats with George N. Bates, M.D., Ohio State Medical Association President-Elect.

Experience: There's Still No Substitute



John H. Budd, M.D., converses with the deans of three of Ohio's six medical schools (left to right): John H. Wulsin, M.D., University of Cincinnati College of Medicine; Dr. Budd; Stanley W. Olson, M.D., Northeastern Ohio Universities College of Medicine; and John R. Kemph, M.D., Medical College of Ohio at Toledo.

Dr. Budd has participated in significant AMA changes. During his years as a Trustee, new sections have been added to the AMA membership including sections encompassing nuclear medicine, emergency medicine, and interns, residents, and medical students. The latter are now the fastest growing segments of the AMA.

Dr. Budd has served on several other AMA Board of Trustee Committees, including the Health Service Review Committee of which he is chairman. This committee has a liaison function with councils and committees such as medical service; environmental, occupational and public health; mental health; maternal and child care; and emergency medical services. Dr. Budd was on the Board's Committee on Osteopathy. He has given testimony for the AMA before the U.S. Senate Subcommittee on Health and before the Food and Drug Administration on drug bills.

As an AMA Trustee, Dr. Budd has been called upon to make many visitations. He has represented the AMA before service clubs, nursing organizations, colleges, specialty societies, and many state and county medical societies in every part of the country.



John H. Budd, M.D., is in a position to contribute significantly to the AMA. He is experienced in the activities and operations of the AMA. John Budd has learned from his years in the mainstream of AMA activities. He has the knowledge necessary to competently perform in a position of authority.

John Budd is able to preserve the viewpoint of the practicing physician because he himself is actively engaged in clinical medicine. Dr. Budd has had a solo family practice in Cleveland, Ohio, for 39 years.

He has said, "The active practice of medicine has kept me aware of physicians' attitudes, aspirations, and problems; contact with my practitioner colleagues has fortified my confidence in the private practice of medicine and my pride in its accomplishments."

John Budd is also concerned about current and future medical care in the United States. He has spent his life improving health care. It seems only natural that his devotion and wealth of knowledge should be placed in one of the most important of medical positions.



These Are the Issues

The AMA has taken a more aggressive attitude toward government in the last year or two and has instituted lawsuits in several areas. Do you approve of this litany?

I do, indeed; and I feel that the AMA's actions are well-justified. They have been taken to assure that physicians can continue to provide the best quality care without hindrance due to governmental interference. We are in good company, as other prestigious organizations are taking similar action. For example, the Joint Commission on Accreditation of Hospitals (JCAH) successfully sued the Department of Health, Education, and Welfare (HEW) for violating confidentiality by publishing JCAH findings on hospital surveys. These were given to HEW for purposes of assessing thoroughness and efficiency of the JCAH's operation. The hospital associations, American, Protestant, Catholic, and investor-owned, sued HEW and won restoration of differential reimbursement for care of Medicare patients.

Comment on the justification of the AMA's suit on the Maximum Allowable Cost Program (MAC).

Under the proposed legislation, the maximum charge permitted for a drug prescribed in federal health programs would be the lowest price of a brand considered equivalent by a Pharmaceutical Reimbursement Board of HEW employees. Substitution of this board's authority for the judgment of the physician—who is responsible

for the medical and legal consequences of his prescribing—is, in my opinion, wrong. It violates the physician's right of practice and the patient's right to benefit from his physician's best medical judgment.

Q. Please comment further on FDA activities as they apply to the practice of medicine.

A. The FDA does have important responsibilities under the law. Originally, the agency's duty was to insure the safety and purity of drugs; but since 1962, it has also been charged with determining the effectiveness of drugs and monitoring the claims made in advertising and promotion. This is a very large assignment and, I believe, beyond the Department's capacity of money and personnel. These expanding duties have often had adverse results: delaying availability of important new drugs, removing useful older drugs, unreasonably eliminating certain effective drug combinations, and ill-advisedly restricting drug use to FDA-approved label indications. The latter, especially, has had the effect of denying patients the use of some effective drugs and of greatly increasing the physician's professional liability jeopardy if he does use them. Lidocaine and Dilantin® in management of cardiac arrhythmias are examples of this drug-use restriction. The Department's intentions may be good, but I recommend more consultation with practicing physicians and more heed to their judgment and experience.

(continued on page 302)



A lively conversation at an AMA Board of Trustees meeting (left to right) AMA President Max H. Parrott, M.D.; AMA Trustee John H. Budd, M.D.; and AMA Trustee Jere W. Annis, M.D.

His Diagnosis

Q. How do you feel about physicians' unions?

A. Unions are a response to the frustrations and resentment we physicians feel over increasing government intrusion into the practice of medicine, discriminatory legislation, and limitation of professional freedom. I understand this reaction and share these sentiments. However, unions, as a rule, bargain with "employers." As a private, practicing physician, I consider myself an independent contractor. My employers are a large group of individual patients—not insurance companies, hospitals, government agencies, or industry.

Thus, at the present time I do not feel that a union is appropriate for me, though I have no quarrel with physicians' unions or their goals. If I become a public utility agent or a government employee, I may, indeed, need to seek the protection of a union. Meanwhile, I am pleased that we in the AMA have organized a Department of Negotiation, and I am watching it with a lot of optimistic anticipation. Organized medicine as represented by the AMA can fulfill many of the objectives of unions.

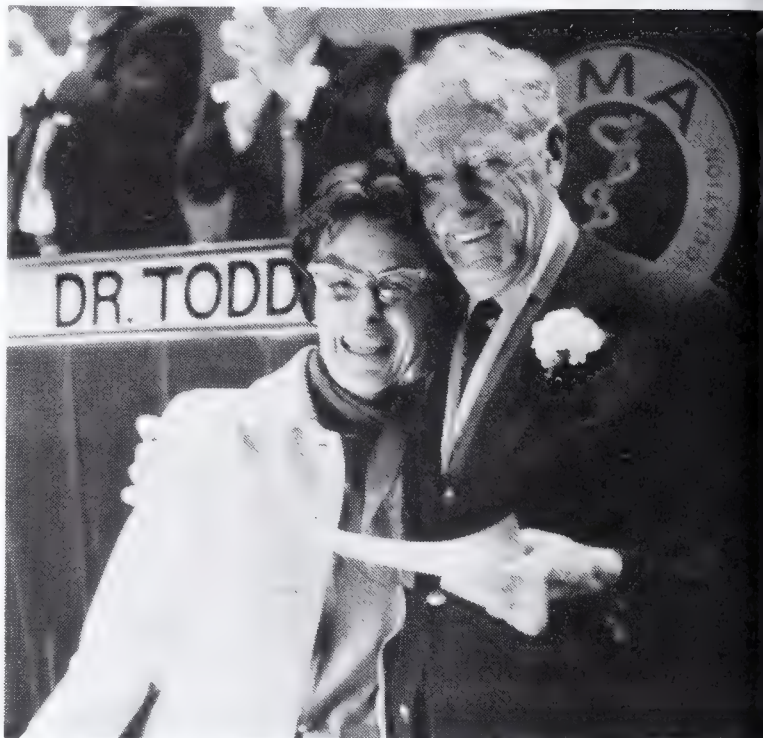
Q. What do you think about the Federal Trade Commission's accusation that the AMA prohibits advertising and, thus, increases medical costs?

A. The charge is as false as it is ridiculous. It must be refuted and defeated in court if necessary, and the AMA's ethical policies must be upheld. The FTC's function is supposed to be to preserve the free, competitive market and to prevent unfair competition or deceptive practices. The AMA's ethics are not in violation of these principles. The AMA censures solicitation of patients but encourages publishing of information on location, type of practice, office hours, moves, openings, new associations, and so forth. The details are governed by good judgment and



Left to right: John H. Budd, M.D., and Max H. Parrott, M.D., AMA President, at an AMA function.

local custom. The ethical, honest physician would not "advertise" further. If advertising were unrestricted, the unethical physician would take full advantage and the public would be the victim.



Dr. Budd is pictured with Mrs. Howard Liljestrand, President of the AMA Auxiliary, and an AMA-ERF check. Well over \$1 million was raised in 1975 for AMA-ERF by the Auxiliary.

Q. Is professional liability a real threat to the practice of good medicine?

A. Yes. It is undoubtedly the most urgent and frustrating problem physicians face. Again, the public is the victim. The situation is intolerable, and I am not greatly encouraged by progress to date in finding solutions. There is no one, over-riding cause and, thus, no single, major solution. A complex, social malady has been caused by numerous factors including aggressive lawyers, defense costs as well as plaintiff attorney contingent fees, the something-for-nothing philosophy rampant in our society, and juries and judges who confuse sympathy with justice and grant huge awards. In addition, insurance companies thriftily prefer to settle a nuisance case for maybe \$2,000 rather than win at a cost of \$15,000. These settlements encourage suits. The occasional incompetent or negligent physician who needs discipline or correction by the profession is also a significant and admitted factor. Discipline or correction is a responsibility of the profession.

Since state laws vary, legislative remedies should be at the state and not the federal level. The immediate problem is to guarantee availability of insurance. However, if the cost is prohibitive, then insurance is not really available.

Physicians have no right or desire to seek immunity from liability for harm caused by negligence, but a



John Budd, M.D., meets with leaders of the Ohio State Medical Association (left to right): Maurice F. Lieber, M.D., OSMA President; Dr. Budd; and Hart F. Page, OSMA Executive Director.

verse result despite the utmost care and skill should not be a professional liability, and malpractice awards should not be made simply because a result was less than expected.

What do you think of the pressures for Health Maintenance Organizations (HMOs)?

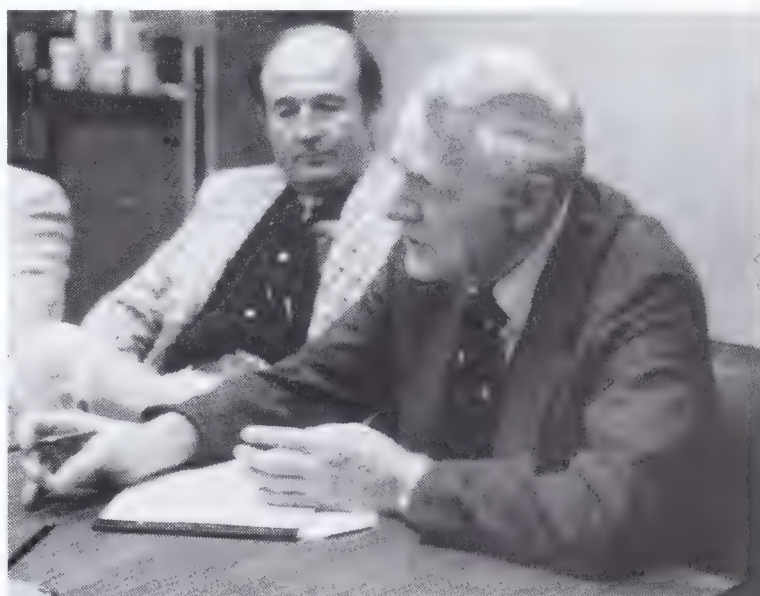
HMOs are not a new idea. Closed-panel, group practice, with comprehensive coverage and prepaid-per-capita payment has been around for 40 years. There are situations where the system is acceptable and, maybe in some cases, even preferable. Its establishment as an exclusive, or even federally preferred method of delivery of care could be unacceptable. Where HMOs have been organized, most of them repeatedly fail to enroll more than 10 percent of the population. The greatest reluctance to accept the system is shown by the largest group involved—the patients. I have no objection to HMOs competing with fee-for-service practice on a fair and equitable basis. I do regard as wrong granting them preferential tax treatment, selective enrollment privileges, and government subsidy.

What is your position on National Health Insurance (NHI)?

I am opposed to compulsory, federally controlled, government-financed national health insurance. Insurance *IS* the best protection against the cost of illness, but those who can provide their own should do so; those who

are indigent should be eligible for government subsidy. The insurance should be offered through private carriers; should be adequate in coverage but devoid of extravagant non-essentials; should be economically sound; and, where possible, should be protected against abuse through cost-sharing by the subscriber. Enthusiasm for government-financed-and-managed NHI has understandably cooled in the past year or so because of increased concern over its cost and awareness that the country's financial resources are not unlimited.

(continued on page 304)



John H. Budd, M.D., often attends the meetings of the Ohio State Medical Association Council.

Rx: Integrity

Q. Do you favor "catastrophic" coverage?

A. Yes. Obviously, protection against financial ruin is of paramount importance to every individual and a proper concern of society.

Catastrophic insurance, however, should supplement, not replace basic benefit insurance. Its eligibility level should be geared to income, or to tax liability, or to some other flexible means test; and its exclusions conspicuously declared.

The incidence of catastrophic illness is relatively low, and many of the really catastrophic conditions are not covered, such as the permanent invalidism of senility, organic brain syndrome, quadriplegia, or the totally crippled stroke victim. When these conditions are non-terminal, become stabilized at irreversible helplessness, and require non-skilled, personal, aids-to-daily-living care, the service is considered "custodial" and is excluded from coverage. For these reasons, the cost of catastrophic insurance is rather low—but the coverage is often inadequate, and the real catastrophe is not covered. The ruinous cost of long-term custodial care, if it is to be provided, should be via a mechanism other than health insurance.



Left to right: John H. Budd, M.D., and Theodore J. Castel, M.D., Past-President of the Cleveland Academy of Medicine.



John and Irma Budd

In Just One Lifetime . . .

Examination: His Credentials

John H. Budd, M.D., was educated at Dalhousie University, Halifax, Nova Scotia, from which he received his medical degree in 1933. Subsequently, he interned at Victoria General Hospital, Halifax, and St. Vincent Charity Hospital, Cleveland, Ohio. He completed residencies at St. Vincent and Evangelical Deaconess Hospitals, Cleveland.

Dr. Budd lists among his many professional affiliations memberships in the American Medical Association, the Ohio State Medical Association, and the Cleveland Academy of Medicine. He is also a Fellow of the American Academy of Family Physicians and a member of the World Medical Association. Additionally, John Budd is a founding member and former president of the Board of Medical and Surgical Consultants of the Cleveland Safety Department.



This extraordinarily involved physician has been the recipient of numerous awards. The OSMA presented him with the Distinguished Service Citation in 1974. Dr. Budd received a Citation for 25 Years Uncompensated Service from the Selective Service System in 1973, and a Special Citation was conferred upon him by the Deaconess Hospital Board of Trustees in 1974.

The Academy of Medicine of Cleveland awarded its hard-working member the Honors of the Academy in 1967. Later, they bestowed upon him Distinguished Membership in 1973 and a Special Award in 1974. The latter represented by a portrait of Dr. Budd permanently on display in the foyer of the Academy of Medicine of Cleveland. Dr. Budd is the only member of the Academy, whose current active roster approaches 3000 physicians, honored while living.

John H. Budd, M.D., served as President of the Cleveland Academy of Medicine. In addition, his local activities include membership on a number of Academy committees: Blue Cross Medical Advisory Committee, Public Policy and Legislation Committee, Legislative Liaison Committee, Honors Committee, Hospital Chief of Staff Committee, Health Insurance Appeals Committee, and Public Relations Committee. Dr. Budd is also a Delegate to the OSMA House of Delegates and has chaired many reference committees.

On the state level, Dr. Budd served as a member of the OSMA Delegation to the AMA from 1960 to 1970; he was Chairman of the Delegation from 1962 to 1970. He has also been a member of a number of OSMA committees: Membership and Planning, Public Relations and Economics, and Ohio Medical Indemnity, Inc. Study Committees.

Dr. Budd was an AMA Delegate to the World Medical Association and a member of the American Medical Association-American Bar Association Joint Conference Committee. In addition, he is the commissioner representing the AMA on the National Medical Liability Commission and is a member of the Executive Committee of the Commission. He is also Vice-President of AMA-ERF and was the delegate representing the AMA on the National Council on International Health.

John Budd has participated in many civic activities: Cleveland Citizens Hospital Study Committee, Cleveland Hospital Facilities Survey Committee, Cleveland Health

(continued on page 306)



Consultation: Your Opinion, Your Vote For John H. Budd, M.D.



John H. Budd, M.D., poses with his portrait which hangs in the foyer of the Cleveland Academy of Medicine.

Goals Committee, and Regional Hospital Planning Board. He was a trustee of the Cuyahoga County Cancer Society and participated in the Speakers Bureau of the society. Dr. Budd has been a trustee of Blue Cross of Northeast Ohio since 1954 to the present and has served on its Executive Committee and its Physician's Research Committee. He has also held membership on the Board of Trustees of the Cleveland Medical Library Association.

Dr. Budd is on the Active Staff of Deaconess Hospital, Cleveland; the Honorary Staff of Parma Community General Hospital, Parma; and the Consulting Staff of St. Vincent Charity Hospital, Cleveland. He has also served each of these institutions in a variety of other capacities.

John Budd was a medical officer in the United States Army during World War II, serving in the European Theater Combat Zone from the Normandy Invasion to VE Day. He was chief of a neurosurgical team in the 4th Auxiliary Surgical Group and was the recipient of five Battle Stars.

Dr. Budd is an exceptional musician whose forte is the piano: he can often be seen joining a jazz session. He is a former orchestra leader and arranger with recording credits. Sportswise, he is an avid baseball and hockey fan.

Dr. Budd and his wife, Irma, have two sons: John H. Budd, Jr., an attorney, and Charles F. Budd, M.D., an orthopedic surgeon.



Left to right: John Budd, M.D., shares a story with Alexander Lagusch, Cleveland Academy of Medicine Assistant Executive Director, and Robert A. Lang, Ph.D., Cleveland Academy of Medicine Executive Director.



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A regular meeting of the Council of the Ohio State Medical Association was held Saturday, March 13, and Sunday, March 14, 1976, at the OSMA Headquarters' office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Drs. George N. Bates and Thomas W. Morgan); James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; P. John Robeck, M.D., Cleveland, Chairman of the OSMA Delegation to the AMA; Drs. Oscar W. Clarke, Gallipolis; Harry K. Hines, Cincinnati; Robert N. Smith, Toledo; Jerry L. Jammon, West Milton; Charles L. Hudson, Cleveland and Charles E. Jaekle, Defiance, all members of the Ohio Delegation to the AMA; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Holcomb, Mrs. Wisse, Mrs. Dodson, Mrs. Jacobson and Ms. Doll, of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Dr. Bates); Mr. Pohlman, Mr. Robeck, and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Holcomb, Mrs. Wisse and Mrs. Dodson, of the OSMA Staff.

The meeting was called to order by President Lieber.

The minutes of the January 31-February 1, 1976, meeting of the Council were approved.

MEMBERSHIP

Membership statistics were reported by Mrs. Wisse and were accepted for information.

The comptroller was instructed to forward to Counsellors, AMA Delegates and AMA Alternates the names of physicians who have dropped their AMA membership, so that these individuals may personally discuss with them the need to support the American Medical Association.

Also requested by the Council were figures on the percentage of AMA membership loss by district, and a list of those county medical societies who have not certified 1976 dues as of this date.

FISCAL MATTERS

The minutes of a meeting of the Committee on Auditing and Appropriations, held March 13, 1976, were presented by Dr. Thomas and were approved.

AMERICAN MEDICAL ASSOCIATION

Dr. Robeck reported on a meeting of the Ohio Delegation to the AMA, held March 12, 1976.

The delegation presented the following nominations for the following year: Dr. P. John Robeck, Chairman, and Dr. Oscar W. Clarke, Vice-Chairman. The candidates were duly elected. Under the rules of the delegation, the president of the Ohio State Medical Association serves automatically as cochairman of the delegation.

Dr. Robeck appointed Dr. Harry K. Hines as Hospitality Chairman; Dr. W. J. Lewis as Resolutions

Chairman; and Dr. Oscar W. Clarke as Chairman of Elections and Candidates.

ANNUAL MEETING

The Council received 47 resolutions which were presented in conformance with the 60-day deadline specified in the Bylaws.

Information was received concerning a change in management and in the fiscal condition of the Cleveland facilities the Association had planned to use as headquarters of the 1978 Annual Meeting.

After study and discussion of the problems, which affect the meeting plans of the Association, the Council voted to schedule the 1978 Annual Meeting in Dayton, May 7-11, 1978.

OHIO MEDICAL INDEMNITY, INC.

Mr. Gillen reported on the meeting of the Board of Ohio Medical Indemnity, Inc., held February 4, 1976.

Dr. Henry reported the nominating committee had recommended the following persons be nominated and elected to the OMI Board of Directors for the ensuing year: Ben Arnoff, M.D., Columbus; Dwight L. Becker, M.D., Lima; William T. Blair, Columbus; Albert A. Brust, M.D., Dayton; Guernsey H. Cole, Jr., Middletown; Joseph Cionini, M.D., Cincinnati; W. D. Henceroth, D.O., Grove City; Paul A. Jones, M.D., Zanesville; Robert A. McLemore, M.D., Springfield; William E. Sovik, M.D., Youngstown; James B. Ogden, Columbus; Martin R. Otto, Warren; Robert Hetterick, Cincinnati; James G. Roberts, M.D., Akron; Frank D. Robinson, Canton; Robert N. Smith, M.D., Toledo; L. Eugene Duff, Lima; Phillip W. Tefft, Columbus; M. M. Thompson, M.D., Toledo; William R. Schultz, M.D., Wooster; William M. Wells, M.D., Newark.

By official action, the Council approved the nominations presented and authorized the following persons to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting, including the election of directors placed in nomination by Council at this meeting on April 21, 1976: James L. Henry, M.D., Grove City, or Maurice F. Lieber, M.D., Canton, or Robert G. Thomas, M.D., Elyria, or Mr. Hart F. Page, Columbus.

On behalf of the Council, the President was authorized to thank the retiring director for his past service: Dr. Paul N. Ivins, Hamilton, Ohio.

DR. ACKERMAN IS GUEST

Dr. John H. Ackerman, Ohio Director of Health, appeared before the Council to discuss medical and public health problems of mutual concern to the Department and to the Association.

He announced that maternity hospital regulation revisions are in their final form prior to public hearing
(continued on page 310)

before the Ohio Public Health Council and reported on regulations governing abortions. He commended Dr. William Dorner, Jr., of Akron, on his devotion to duty as a member of the Public Health Council.

He asked the assistance of the Association in upgrading the salaries of clinicians in his Department.

Dr. Ackerman discussed problems which would be encountered with proposed Federal block grants, with regard to what the Department could expect in the way of assistance.

The End-Stage Renal Disease Program was discussed and Dr. Ackerman related that he had protested the regulations proposed by the Department of Health, Education and Welfare.

Dr. Ackerman concluded with a "chalk talk" concerning the Health Service Agency program set up by Public Law 93-641. He discussed the areas of grant review, certificate of need, mental health planning, planning in areas of alcoholism, and health care delivery planning, all assigned to the agency by Congressional action.

The Council voted to commend Dr. Ackerman for his devotion to duty as Ohio's Director of Health and to thank him for his spirit of cooperation in furthering the health of Ohio's people.



Left to right: John H. Ackerman, M.D., Ohio Director Health, and Charles W. Edgar, OSMA Director of Public Relations.

COMMITTEE REPORTS

COMMITTEE ON SCIENTIFIC WORK

The minutes of the February 8, 1976, meeting of the Committee on Scientific Work were presented Mrs. Dodson and were accepted for information.

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OSMA PENSION COMMITTEE

The minutes of the February 12, 1976, meeting of the OSMA Pension Committee were presented by Dr. Henry.

A number of changes in the OSMA Employees' Pension Plan were recommended in order to bring the plan into conformity with the Federal Employee Income Security Act of 1974. The amendments were approved by official action of the Council.

The Council voted that the Pension Committee be empowered to monitor and have responsibility for administration of Pension Trust "B," the Employees' Auxiliary Pension Trust Benefits Program.

COMMITTEE ON EYE CARE

The minutes of the February 20, 1976, meeting of the Committee on Eye Care were presented by Mr. Rader and were accepted for information.

COMMITTEE ON PRISONS AND JAILS

The minutes of the February 25, 1976, meeting of the Committee on Prisons and Jails were presented by Mr. Gillen.

The Council approved the Committee's recommendation that the American Medical Association's Medical Care—Health Services—Guidelines and Standards be accepted as a working document.

The report as a whole was accepted.

JOINT ADVISORY COMMITTEE ON SPORTS MEDICINE

The minutes of the February 25, 1976, meeting of the Joint Advisory Committee on Sports Medicine were presented by Mr. Clinger.

Three recommendations of the Committee were approved as follows:

1. That physicians serving athletic teams be urged to communicate elements of risk to players who may have "disqualifying conditions" before the start of the sport season—and that the physicians keep records of these communications. Parents should also be notified—preferably at the same time as the athlete.

2. That the Committee stimulate gathering of data on athletic injuries throughout Ohio for the purpose of producing evidence to substantiate elements of risk.

3. That Dr. Wright be assigned to conduct a study of existing sports medicine guidelines formulated by both AMA and OSMA—OHSAA to determine if they can be substantiated by hard evidence in case of challenge.

The minutes as a whole were accepted.

COMMITTEE ON GOVERNMENT MEDICAL CARE PROGRAMS

The minutes of the March 3, 1976, meeting of the Committee on Government Medical Care Programs were presented by Mr. Gillen.

Maximum Allowable Cost Regulations

The Council first considered a resolution on "Maximum Allowable Cost Regulations" submitted by the Committee for presentation at the 1976 Annual Meeting of the Ohio State Medical Association. The Council amended the resolution and agreed to sponsor it.

The text of the resolution follows:

WHEREAS, The Regulations regarding Maximum Allowable Cost for drugs published in the Federal Register requires "physician certification" as to the medical necessity for a given form of a drug before reimbursement in an amount in excess of the lowest cost for that class of drugs is permitted, and

(continued on page 312)

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Left to right: John G. Gaughan, M.D., OSMA Fifth District Councilor, and Harry K. Hines, M.D., AMA Delegate.

WHEREAS, Each prescription written by a physician in and of itself identifies a medicine or combination of medicines which he or she judges to be necessary for that patient's mental or physical condition, and

WHEREAS, That the best interests of patient's medical care is served by recognition of the fact that the physician is the sole determiner of the proper drug therapy for a given patient's condition, THEREFORE, BE IT

RESOLVED, That the OSMA reaffirm its policy that the physician is the sole determiner of which medicine his patient receives, AND BE IT FURTHER

RESOLVED, That the OSMA expects that each physician prescription will be filled precisely as written, regardless of any third party regulation, and without the necessity of certification of each and every prescription which may or may not fall under the purview of the Maximum Allowable Cost Regulations.

Policy on PL 93-641

After extensive discussion of PL 93-641 and its implications for medicine, the Council adopted the following policy and directed that it be forwarded immediately to all of Ohio's county medical societies:

OFFICIAL POLICY OF THE OHIO STATE MEDICAL ASSOCIATION REGARDING PUBLIC LAW 93-641, THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974.

The Association herewith reiterates its strong and definite position that this law is dangerous to the provision of quality medical care and that it violates the Constitutional rights of both the consumers and the providers of health care.

The Association took the position, when this legislation was pending in Congress, that it was bad legislation that should not be passed. This position was presented forthrightly to Ohio's Congressmen and United States Senators.

When Congress enacted the legislation, the Ohio State Medical Association urged President Ford to veto it on the basis that it would be detrimental to the preservation and expansion of quality medical care in the United States.

The Association strongly supports the declared intention of the American Medical Association that legal action will be taken when such action becomes feasible. Further, this Asso-

ciation endorses and urges all Ohio physicians to support the position of the American Medical Association, namely:

"Until such time as legal action is feasible, the Association will follow a course of activity designed to protect the interests of the public and assist the Federation in carrying out its responsibilities. Such assistance will include: review and comment on published or promulgated regulations; participation in conferences and meetings, sponsored by others, to express AMA viewpoints; expansion of AMA Speakers' Bureau subject matter to include addressing this law and its implications; convening of conferences and meetings to publicize AMA's concerns and provide a forum for discussion within the profession; provision of information and assistance in response to specific requests from the Federation; at the request of medical societies, cooperate, where desirable, with Health Systems Agencies with respect to informational needs; and the assignment of substantial space in AMA publications to the coverage of developments in the law."

The OSMA calls on Congress to repeal this undesirable act.

Further, the Ohio State Medical Association urges all its component medical societies and all its physician members to inform themselves, fully and deeply, as to the specific content of Public Law 93-641, to insist that physicians have a meaningful and effective role in health planning developments and in Health Systems Agencies within their Health Service Areas and to strive to protect the medical rights and medical best interests of their patients.

The Council of the Ohio State Medical Association emphasizes that the resources of the Association are available to its component medical societies and to physician members in carrying out the precepts of this position regarding Public Law 93-641.

COMMITTEE ON CANCER—OHIO CANCER COORDINATING COMMITTEE

The minutes of the March 6, 1976, meeting of the Committee on Cancer—Ohio Cancer Coordinating Committee were presented by Mr. Clinger.

Recommendations that the *Ohio State Medical Journal* list upcoming continuing medical education programs in the cancer field and that a review article containing scientific material slanted to the primary care physician on a rotating basis with other medical specialties were approved.

A proposal for the "Elements of a Plan for Cancer in Ohio" was received for study only.

Regarding a recommendation that the Ohio State Medical Association sponsor legislation in the Ohio General Assembly calling for a special sales tax of two cents per pack of cigarettes sold in Ohio—with all revenues earmarked for the Ohio Department of Health to be used in cancer control—the Council accepted the proposal in principle but voted not to actively pursue the matter at this time since the present social climate decries additional taxation, and because experience has demonstrated that so-called "earmarked" funds often do not reach their destination.

The report of the Committee as a whole was accepted as amended.

(continued on page 314)



Left to right: W. J. Lewis, M.D., OSMA Second District Councilor; Robert G. Thomas, M.D., OSMA Eleventh District Councilor; and Robert N. Smith, M.D., AMA Delegate.

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COUNCIL FEE REVIEW COMMITTEE

No action taken.

COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS

The minutes of a conference of the Committee on Judicial and Professional Relations held March 8, 1976, were presented by Mr. Page.

The Council studied guidelines for "specialty listings" in metropolitan telephone directory "yellow pages" as presented by the Committee and instructed the Executive Director to forward them to the telephone company with the message:

"If you list physicians and surgeons-M.D., by specialty headings, these are recommended guidelines.

"Please understand that this advice **does not constitute an endorsement** of the specialty headings listing by the Ohio State Medical Association."

AD HOC COMMITTEE TO STUDY OHIO FOUNDATION FOR MEDICAL CARE

The March 4, 1976, meeting of the Ad Hoc Committee to Study OFMC Proposed Activities was reported by Dr. Thomas.

The Council directed that OFMC prepare a written report covering all aspects of the Foundation system, including its functions and goals, for the consideration of the Council.

TASK FORCE ON PROFESSIONAL LIABILITY

The minutes of the February 5, 1976, and the March 11, 1976, meetings of the Task Force on Professional Liability were presented by Mr. Rader.

The Council **approved** the following recommendations of the Task Force with regard to anticipated "ISO" (Insurance Service Organization) malpractice premium rate filings.

1. That the OSMA develop a statement opposing any malpractice rate increase filings.
2. That the OSMA should request formal hearings by the Ohio Department of Insurance in the event ISO filings are made at greatly increased premium rates.
3. That the OSMA develop a statement to inform OSMA membership of possible ISO rate increases and current Task Force activities.

The February 5 minutes were accepted.

Mr. Rader presented the minutes of the March 11 Task Force meeting. The Council considered proposals made by representatives of the Ohio State Neurosurgical Society, and amended and adopted the following Task Force recommendations:

1. The OSMA should continue to work with the State Medical Board to provide quality health care delivery in Ohio and to encourage the Board to strengthen its activities through utilization of the language gained by the passage of H.B. 682. The Task Force submitted the comment that historically it is the "more skillful" doctor, not the "less skillful" doctors who have had a higher incidence of malpractice suits.

2. The OSMA should endorse and cooperate with the high risk specialties in a solicitation of funds for a court docket survey and this funding should be used in part to investigate and develop background information concerning possible countersuit activity in Ohio in appropriate medical malpractice cases. Data development already being undertaken by the OSMA through a nationally respected actuarial firm and a portion of the solicitation should go toward offsetting the costs of the actuarial studies. The funding should be done through separate solicitation coordinated by the OSMA Task Force on Professional Liability, and not through OSMA dues dollars.

3. The Public Relations Department of the OSMA is already working very hard in the area of malpractice news releases and has been working with OSMA spokesmen for some time developing news media coverage in this area, and should continue to do so.

4. An area around Columbus could be used for a court docket survey described in Item #2 but some other cities should definitely be included so that the data may be statistically viable.

The Council adopted a recommendation of the Task Force that OSMA staff continue the development of background data concerning the establishment of a captive professional liability insurance company and that a report be available for the 1976 OSMA House of Delegates meeting.

The March 11, 1976, minutes were **approved** and amended as a whole.

OTHER MEETINGS

Mr. Page reported on meetings with the Ohio State Medical Board (February 11) and with the Joint Officers of the Ohio Hospital Association and the Ohio Association of Osteopathic Physicians and Surgeons (February 11).

Mr. Clinger reviewed the Ohio Health Council meeting (February 11) and the Disabled Physician Seminar sponsored by AMA (February 17-18). Dr. Well reported on a meeting with representatives of the Ohio Podiatry Association (February 12), and Mr. Campbell on a meeting of the Board of Directors of the Joint Underwriting Authority (March 9). Mr. Holcomb reviewed Executives' Day (February 18).

(continued on page 316)

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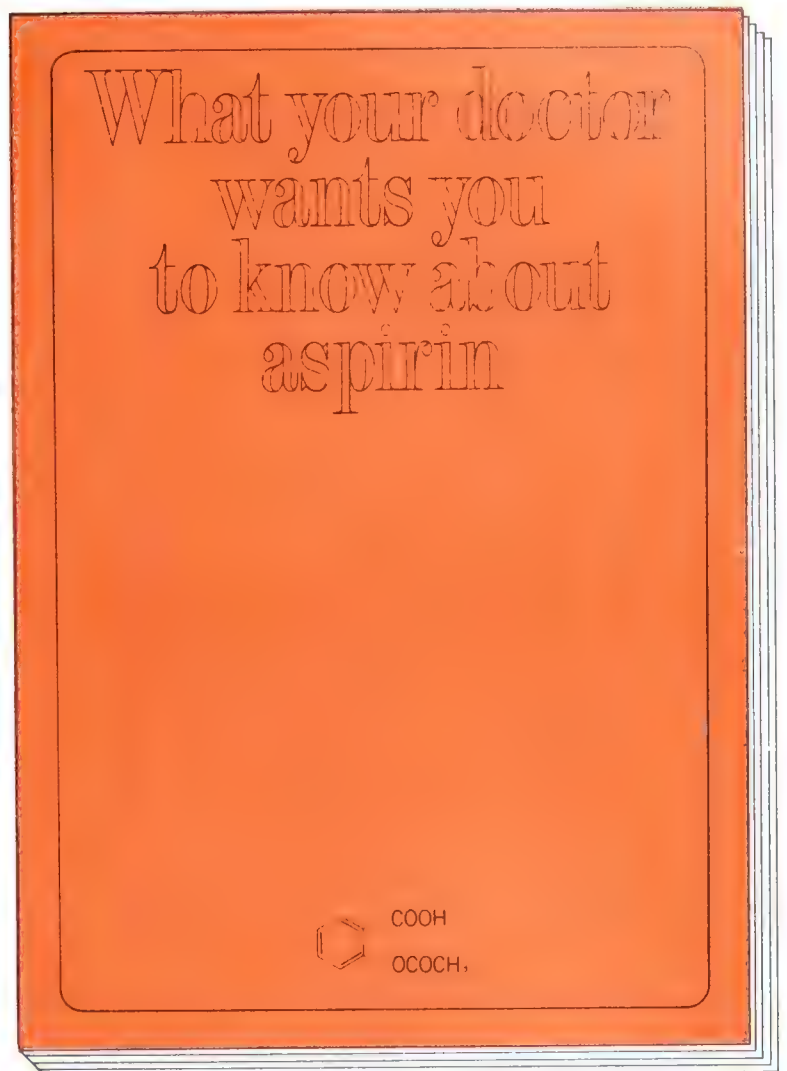
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*Moertel, C.G., et al: N. Engl. J. Med. 286:813 (Apr. 13) 1972.



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(Proceedings continued from page 314)

COUNCILOR REPORTS

The Councilors reported on various activities in the respective districts and discussed grievance and professional liability matters therein.

FEDERAL LEGISLATION

A communication from the Louisiana State Medical Society regarding H.R. 6222, Medigredit, was received for information.

Mr. Edgar reported on the status of health manpower legislation, the status of health maintenance organization legislation, and on hearings being conducted by Congressional committees in regard to nationalized health care proposals. He also reported that corrective amendments have been adopted for S. 1737, the Clinical Laboratories Improvement Act of 1975.

MEDICARE STATUS REPORT

A formal progress and status report on the Part "B" Medicare Program in Ohio was presented to the Council by Mr. Hugh F. Hughes, Manager, Medicare Field Operations.

OHIO STATE MEDICAL JOURNAL

Mrs. Jacobson reported on the status of the effort of United Media Association, Inc., to obtain advertising for *The Journal*.

A report with regard to tax problems of association publications was received and the Council voted "to support the American Society of Association Executives proposed amendments to the I.R.S. Code relating to income tax of trade and professional organizations and other tax-exempted organizations for advertising contained in publications provided to members."

MONROE COUNTY NHSC

An application for one physician, under the National Health Service Corps program in Monroe County, previously approved by the Monroe County Medical Society was approved by Council.

FIELD SERVICE REPORT

Mr. Holcomb presented a report on field service activities and future meetings planned by that Department.

DR. HENRY COMMENDED

A motion by Dr. Hogg, seconded by several, and carried, commended Dr. James L. Henry for his vision, dedication and unfailing devotion to medicine, during his years on the Council of the Ohio State Medical Association.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page,
Executive Director



The Swamp Physician: Medical Practice in Northwestern Ohio Around 1850

WALTER H. HARTUNG, JR., M.D., and MAX T. SCHNITKER, M.D.

About one million years ago in the northwestern part of the land which eventually became the State of Ohio, a valley was created by the glacial movements of the Ice Age. Through this valley passed a stream whose name, engendered by the French as "Miami" (Mē-ámē)¹ and mispronounced by American soldiers during the War of 1812, came to be known as the Maumee River. The fertility of the soil, the variety and numbers of wild game, and the accessibility of several waterways, including the Great Lakes, proved to be attractive forces for the adventurous. (Fig. 1). However, polluted water and swamps throughout the region were continual sources of disease, challenging man's presence and destroying his life. Because of this, the settlements cried out for medical care.

Before 1800, the Jesuit missionaries from Canada served as physicians for the Indians and white trappers in this area. As more settlers arrived in the region now recognized as the city of Maumee, physicians began to establish their practices there. They came from Vermont, New York, New Jersey, Connecticut, Washington, D.C., Canada, and Europe with varying amounts and forms of education in the art of medical practice.

What really brought physicians to this region? When asked this question in 1888, one physician replied: "Chance, not choice, frequently led to the opening of an office."²(p541) Another said: "We came to this place . . . not because we had ever heard of the place, but because in trying to get to a chosen field, we got stuck in the mud here. To go back was mud; to go forward was more mud:

and so we planted ourselves here to grow up with the country and benefit those who might desire our professional assistance."²(p541) These simple words truly reflect the dedication so characteristic of swamp physicians.

Around 1800, a Dr. Barton began his practice of medicine in Maumee. He was followed by Dr. Horatio Conant (1816) and by Dr. Walter Colton (1823). In 1825, Dr. J. V. D. Sutphen was the first physician to settle in Toledo. He was followed by Dr. Oscar White in 1829 and by Dr. John Fasset in 1832. In 1833, Dr. Welcome Pray began his practice in Waterville. In 1834, Drs. Blakesley H. Bush, Jacob Clark, and John Mosher settled in Toledo. They were followed in 1835 by Dr. Horace Green and in 1836 by Drs. Horace A. Ackley, James L. Chase, George R. Perkins, Manley Bostwick, Charles McLean, and Baxter Bowman. Truly the call of the settlement was being heard. The list of practitioners grew rapidly to include Drs. Symmes H. Bergen, John W. Bone, William C. Chapman, Gustave F. von Fenneberg, Isaac N. Hazlett, Franz J. Klausner, Chauncey Matthews, Calvin H. Reed, Samuel W. Skinner, Alfred Taylor, and Samuel S. Thorne.

Dr. James L. Chase, speaking before the Toledo Medical Association in 1876, stated that when he came to this area in 1836 "quinine was worth \$16 per ounce and the streams in the county were without bridges."³ The major means of transportation were the horse and the canoe. Cholera and malaria were everywhere. In 1837, the population of the area was about 500. During this year, 37 adults died, the major cause of death being infection. According to Dr. Chase, "Sandusky was the best supplied with medical men,"³ but the mortality rate was just as high as in Toledo. He also emphasized the degree of pollution of the waters in the area, reporting that he had seen "not only frogs but snakes and mud turtles cross the Maumee River on a green scum that was so thick it could bear them."³

The swamp physician met the challenges of general practice with very few therapeutic and diagnostic aids. His dedication to serve his fellow-men demanded complete self-sacrifice and inexhaustible effort. His medical practice extended over quite a large geographic area—sometimes covering up to 30 miles. To attend his patient, the physician had to walk, use a canoe, or ride a horse (Fig. 2). One episode is recorded in which a physician had to swim across waterways eight times in order to bring health care to his patient.

(continued on page 318)



TOLEDO IN 1800.

Fig. 1. Toledo in 1800. View of west bank where the Maumee River passes the downtown area.² (Photo of print by Robert Acko.)

The Swamp Physician (continued)

The swamp physician carried his medical supplies in a pill bag or saddlebag (Fig. 3). These supplies included calomel aloes, Dover's powder, opium, "sweet spirit of niter" (spirit of nitrous ether), "Spanish fly" (cantharis) for "drawing" blisters, Peruvian bark (cinchona) or sulfate of quinine for "ague," a lancet for bloodletting, and a "turnkey" for extracting teeth. Soaks, plasters, poultices, and herbs were common features of his therapy.

"With no roads save bridleparks, he often was compelled to ride horseback days at a stretch in order to reach his patients; fording streams; wet often for hours, and chilled with fierce winds, often in winter having his clothing frozen upon his person, there being no houses to stop at; riding day and night, summer and winter, keeping a relay of horses where most needed. This he did for many years, and until the laborious and exhausting effects of his efforts made him prematurely aged and infirm, and necessitated the abandonment of his much beloved profession."²(p542)

Characteristically, the physician became very much involved in community life and the advancement of his profession. He was unselfish in extending to other physicians the knowledge he gained from long days of medical service. This led to the formation of an association with other physicians to improve the quality of medical care and maintain a high level of community



FIG. 2. Ready for a House Call. The swamp physician with horse and saddlebags extended health care to the citizens of his community. (From a photographic print in *Medical World News*. Photo of print by Robert Packo.)

health. Around 1840, the Maumee Valley Medical Association was established with Dr. E. D. Peck of Perrysburg as president. In 1851, the Toledo Medical Association was organized; but because of a cholera epidemic, no meetings ever were held. It was reorganized on July 2, 1856, with Dr. Jacob Clark as president. In 1894, the Lucas County Medical Society was formed. In 1902, it merged with the Toledo Medical Association to become

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FIG. 3. The Pill Bag (From *Medical World News*. Photo of print by Robert Packo.)

the Academy of Medicine of Toledo and Lucas County which became formally incorporated in 1909.

Inflamed with a desire to educate, the swamp physicians established the Toledo School of Medicine in 1878, which was somewhat of a peripatetic school. In 1882, the faculty was enlarged and the curriculum expanded. The school then was incorporated as the Northwestern Ohio Medical College. This school closed in 1892. Also in 1882, the Toledo Medical College was incorporated.⁴ It discontinued its functions in 1914 following the historic survey of medical schools by Dr. Abraham Flexner. Nevertheless, the educational desire persisted, engendering the establishment of the Medical College of Ohio at Toledo in 1969 (Fig. 4).

Because of the value of accumulated experience and the demands of good medical practice, the need for formal communication through a medical journal became recognized. In 1877, the *Toledo Medical and Surgical Reporter* began periodic publication through the Toledo Medical Association. This journal was edited by Drs. Jonathan Priest, William C. Chapman, and Thomas Seddell. In 1884, the *Toledo Medical Compend* appeared on the local scene under the editorship of Dr. Clarence S. Miller. Several local physicians in the late 1800s contributed many informative reports in the national medical literature. Dr. Allen DeVilbiss reported on "Saws and Their Application in Nasal Surgery," "New Devices for Cutting Bone," "What Can and Cannot Be Done for Nasal Catarrh by Local Application" and "The Technique of Resection of the Skull." His research and ingenuity led to the development of the DeVilbiss nebulizer and the founding of an international industry.



FIG. 4. Toledo Medical College, 1908 (From postcard published by W. L. Milner & Co., Toledo. Photo of print by Robert Packo.)

The calamitous Civil War demanded the attention of many of the local physicians on far-away battlefields and encampments. However, with their return to the Toledo area, they brought further experience and skill that added to the rising tide of medical progress. In 1861, the members of the Toledo Medical Association agreed to "attend the families of Volunteer Soldiers without charge during their employment in active service."⁵ In 1864, the members of this association also developed a fee schedule:⁶

City calls	\$ 2.50
Country calls, per mile	.50
Double rates for night calls	
Obstetrical delivery, 'natural'	10.00
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(continued on page 320)

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The Swamp Physician (continued)

Associated with the rising tide of medical progress was the growing need for a hospital. In 1855, the Grey Nuns of Montreal established St. Vincent's Hospital. Following this, the Young Women's Christian Association founded the City Hospital of Toledo, which later became Protestant Hospital of Toledo (1893). In 1901, with the addition of 50 beds, the name was changed to Toledo Hospital. Flower Hospital (1910), Mercy Hospital (1918), Robinwood (now St. Luke's), Women's and Children's Hospital (now Riverside), and East Side Hospital (no longer functioning) followed later. The County Infirmary was opened in 1861. It measured 40 x 50 ft and 12 ft high and cost \$1,058 to build! By 1888, this infirmary had expanded into the Toledo State Hospital for the Insane treating 1,100 patients. The County Hospital (later identified as Maumee Valley Hospital) had its humble beginnings in 1896.

The importance of community health always was recognized by the swamp physicians. Vaccination against smallpox gradually proved its effectiveness. By 1853, four public wells for water were relied upon to serve Toledo; a more efficient waterworks system was established in 1873. In 1860, The Miami Children's Center extended love and care to the children of broken homes, a concept followed by St. Anthony's Orphanage (now St. Anthony's Villa) and the Sunshine Children's Home.

Cholera epidemics in 1849, 1852, and 1854 spread a pall over the area. Treatment of this disease took many forms. Dr. Jacob Clark's most successful method was bloodletting. He urged the practitioner to "bleed until you think you are killing the patient, and he will get well."^{2(p545)} Dr. Walter Colton, however, recommended "partaking inwardly of cold water only, and injecting the veins with a large quantity of common salt in warm water."^{2(p542)}

Dr. Arthur F. Bissell was the first homeopathic physician to appear in Toledo (1848), followed by Dr. Samuel S. Lungren in 1860 and Dr. William Rowsey in 1862. In 1842, mesmerism or "animal magnetism" sprang to life locally. Through this form of clairvoyance, one supposedly was able to gain mental control over another person, "fasten one to the floor by a motion of a finger, paralyze (another person's) arm by an exertion of the will; and bring on an attack of the apoplexy, by a single glance of the eye."^{2(p574)}

Whigs, Democrats, and the Republicans created political waters through which several local physicians passed. Dr. William W. Jones (Fig. 5) served three terms (six years) as mayor of Toledo and was elected President of the Ohio State Medical Association in 1875. Dr. Horatio Conant was treasurer and township trustee, judge of the Court of Common Pleas, postmaster, collector of customs, and justice of the peace in Maumee. Dr. Franz Joseph Klauser became consul for the United States in Amsterdam from 1861 to 1863. In 1863 Dr. Daniel Cole became the first coroner of Lucas County. The first health commissioner of Toledo was Dr. L. C. Grosh (1900).

"In 1843 a law was in force in Ohio under which county commissioners were empowered to levy special taxes upon Lawyers and Physicians 'according to their annual incomes.'"^{2(p314)} The taxes ranged from \$1 to \$4. In June 1844, it was decided to tax each lawyer and physician 25 cents.

Toledo became an incorporated community in 1837. Its first newspaper, *The Toledo Herald* (1834), St. Patrick's Roman Catholic Church (1845), streetcars (1862) and a new public waterworks system (1873) were impressive evidence of the increasing demands of a growing community. In 1878, telephone service began in Toledo . . . the end of the physician's "night of rest."

The settlers now had local government, communication, transportation, pure water, and a place to worship. The population increased rapidly and demands on the physician's life intensified. The current of self-sacrifice, perseverance, dedication to help others, and a burning zeal to learn and improve brought more physicians to maintain and extend medical care to the settlement. The swamp physician had set the stage for 20th century medical practice.



FIG. 5. W. W. Jones, M.D. Dr. Jones served as mayor of Toledo for six years. In 1875, he was President of the Ohio State Medical Association. He is not to be confused with Mr. Samuel "Golden Rule" Jones who later also served as mayor of Toledo. (Photo of print by Robert Packo.)

References

1. Killits JM (ed): *Toledo and Lucas County, Ohio* 1623-1923. Toledo, S J Clarke Publishing Co, 1923, p 650.
2. Waggoner C (ed): *History of the City of Toledo and Lucas County, Ohio*. Toledo, Munsell & Co, 1888, p 541.
3. Minutes of the Toledo Medical Association, May 16, 1876.
4. Schnitker MC, Hartung WH Jr: *The Toledo Medical College 1882-1914*, 1973.
5. Minutes of Toledo Medical Association, November 4, 1861.
6. Alderdyce WW, Ockuly EA: *Magnificent Century: An Outline of the History of the First Hundred Years of Organized Medicine in Toledo and Lucas County, Ohio*. Toledo, 1951, p 9.

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DEPARTMENT OF OB-GYN WANTED: Ohio licensed. 350-bed community hospital preferred. Salary \$18,500. Please contact B. Polazic, M.D., Director, 5163 Broadway Avenue, Cleveland, Ohio 44127; Phone: 216/441-3300, Ext. 246.

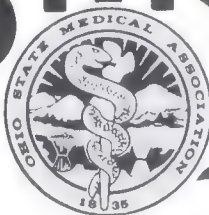
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THREE LICENSED M.D.S: Our acute care general hospital is seeking three (3) full-time, state-licensed physicians for staff duties. We offer a competitive salary with a progressive fringe benefit package (includes paid professional liability insurance). Please send resume to Executive Director, The Womens General Hospital, 1940 East 101st Street, Cleveland, Ohio 44106 or phone: 216/791-2600.

JUNE 1976
Volume 72, Number 6

THE OHIO STATE Medical Journal



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Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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Medical Hotline

OSMA Changes Fee Review Policy

The Council of the OSMA took action on April 28, 1976, to change its policy of fee review. The name of the Council Fee Review Committee was changed to the Medical Services Review Committee to describe more accurately the work of the Committee which hereafter will be limited to the review of disputes involving physicians which arise out of such issues as the utilization of physician's services, medical necessity and appropriateness of medical care.

Council took this action upon the advice of the Association's Legal Counsel, James E. Pohlman, who rendered a formal opinion to the Association.

In his opinion letter Mr. Pohlman advised the Association in part as follows:

The Association has requested legal advice as to whether recent decisions in the antitrust area are applicable to the work of the Ad Hoc Committee which is undertaking a review of the complaint procedures provided free of charge by the Ohio State Medical Association. Recent developments in the antitrust law field are of concern to, and should be considered by, the Committee.

As the most recent report of the Committee points out, there are several types of complaints received and administered by the Ohio State Medical Association, including complaints and disputes relating to the utilization of physicians' services, the quality of physician services, complaints arising from misunderstandings and poor communications between physician and patient, complaints and inquiries concerning possible medical malpractice and, most often, disputes concerning fees. It has been recognized by the Committee that certain disputes may fall into more than one category, i.e., a dispute may involve questions of both the utilization of a physician's services and the appropriateness of his fee.

The activities of the Ohio State Medical Association in these areas have been conducted pursuant to the self-regulatory functions traditionally accorded the professions. However, the recent decision by the United States Supreme Court in **Goldfarb v. Virginia State Bar**, 421 U.S. 773 (1975), raises several difficult questions as to the proper and lawful scope of the self-regulatory activities of a professional organization such as the Ohio State Medical Association.

While there are obvious distinctions between the facts in the **Goldfarb** case (which involved strict adherence to a minimum fee schedule by lawyers in Fairfax County, Virginia who represented purchasers and sellers in residential real estate transactions) and the activities of the Ohio State Medical Association noted above, the rationale and implications of the **Goldfarb** decisions are broadly stated and directly affect schemes of self-regulation prevalent in most professions.

The Supreme Court in the **Goldfarb** case laid to rest one point that had formerly been unclear: whether the so-called "learned profession" exemption to the federal antitrust laws is still viable. It is not. It is a dead letter and no longer insulates activities of professional organizations that would otherwise be subject to the federal antitrust laws. The Supreme Court in **Goldfarb** was quick to find that the strict adherence by the lawyers in Fairfax County, Virginia to the minimum fee schedule adopted by the state bar association (due in part to an ethical opinion rendered by the bar association that habitual

charges less than the suggested minimum fee schedules raised a presumption of ethical misconduct by an attorney) was a "classic illustration of price fixing."

The Supreme Court did, however, recognize that the states have a proper role in regulating the professions but gave little clear guidance for the future as to the proper limits of that role. The Court stated:

"We recognize that the States have a compelling interest in the practice of the professions within their boundaries, and that as part of their power to protect the public health, safety and other valid interests they have broad powers to establish standards for licensing practices and regulating the practice of professions. We also recognize that in some instances the State may decide that 'forms of competition usual in the business world may be demoralizing to the ethical standards of a profession'. . . In holding that certain anticompetitive conduct by lawyers is within the reach of the Sherman Act we intend no diminution of the authority of the State to regulate its professions."

Further evidence of the uncertainty surrounding the Court's decision in **Goldfarb** so far as other self-regulatory conduct by professions is found in a footnote in the opinion which reads:

"The fact that a restraint operates upon a profession is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to review the practice of professions as interchangeable with other business activity, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today. **Goldfarb v. Virginia State Bar Association**, 421 U.S. at 787-788, Footnote 17." (Emphasis added.)

Since the decision by the Supreme Court in **Goldfarb**, at least one lower court (faced with the issue as to whether a provision in the Code of Ethics of the National Society of Professional Engineers prohibiting competitive bidding was exempt under the Sherman Act) has concluded, citing **Goldfarb** that, "Price fixing receives no privileged treatment when incorporated into a code of ethics."

The case involving the Society of Professional Engineers is clearly the first of many professional antitrust cases to follow in the wake of **Goldfarb**. As Bernard D. Hirsh, General Counsel, American Medical Association, has advised AMA Executive Vice President, James H. Sammons, M.D.:

"It can be anticipated that **Goldfarb** will stimulate a rash of antitrust litigation related to the economics of health care delivery that will endure for many years."

Mr. Pohlman further commented that it was "regrettable" that "the present attitude of the Federal Trade Commission and the Justice Department require that this action be taken at this time," and said also that "the public service aspects of the fee reviews traditionally afforded physicians, their patients and third parties should be recognized legally in order that this public service may be reinstituted at the earliest possible time."

Hart F. Page, the Association's Executive Director, assured members that they will be kept advised of future developments on this important subject.

145 Percent Increase Asked for Liability Insurance Premiums

On June 1, 1976, the Ohio Department of Insurance received a filing for a 145 percent increase in medical professional liability insurance premiums. This increase became effective as of the filing date but may be reduced or eliminated by the Ohio Department of Insurance at future public hearings.

The initial filing was made by the Insurance Services Offices (ISO), the organization to which some malpractice insurance companies subscribe to help determine rating structures and premiums. Almost all Ohio malpractice companies except the Medical Protective are members of ISO. In addition, the Joint Underwriting Association also filed for the rate increase effective August 8, 1976.

The OSMA anticipated the filing and took action on June 1, the earliest date allowable. George N. Bates, M.D., OSMA President, issued a formal letter of complaint protesting the increase and requesting a public hearing concerning the basis and reasonableness of the proposed rates.

Dr. Bates' letter read in part: "The OSMA represents many physicians who are aggrieved by the latest ISO filing effective June 1, 1976. . . . It is our opinion that the rate filing by ISO is excessive and unfairly discriminatory."

Examples of the increases for \$100/\$300 coverage when applied to solo practitioners in various fields include: General Practitioner— premium increase from \$1077 to \$2640; General Surgeon— increase from \$5482 to \$13,431; Orthopedic Surgeon— increase from \$8770 to \$21,488.

Bureau of Workmen's Compensation Inquiry Service Expanded

The Bureau of Workmen's Compensation has expanded its telephone service of public inquiries to better serve claimants, employers, and health care providers. If you have been advised of the Bureau's approval of a fee bill but have not received payment of it within 45 days of the approval date, you may call the Public Inquiry Section at 614/466-6703.

The following is a list of information sources for questions regarding workmen's compensation:

Fee Bill Inquiries: Send inquiry to nearest district office.

Medical Authorizations: Send request to nearest district office or to Medical Director at Columbus central office.

Inquiry Recognized in Claim: Call or write district office.

Copy of Preliminary Procedures: Write to Office Services Section.

Question on Disallowance: Call or write nearest district office.

Overpayment or Duplicate Payment: Send copy of remittance advice to Accounts Section.

Question on Remittance Advice: Call or write Public Inquiry Section 614/466-6703.

HEW to Contract With New PSRO

HEW announced in the May 21, 1976, *Federal Register* its intent to enter into a contract with Physician Peer Review Organization for PSRO Area XII (Cuyahoga County) and a contract with Region II Medical Review Corporation (Second OSMA Councilor District) for designation as PSRO organizations.

Licensed physicians in Cuyahoga County and OSMA Second Councilor District engaged in active practice who object to such designation on the grounds that the organization is not representative of physicians in such area, may mail such objection in writing to the Secretary of the Department of Health, Education and Welfare P.O. Box 1588, FDR Station, New York, New York 10022. All such objections include physician's address, location(s) of his office(s), his signature, and he must state that he is engaged in the active practice of medicine or osteopathy.

Conference for Medical Directors Of Skilled Nursing Facilities

The OSMA in cooperation with the AMA and other groups, is sponsoring a conference on the Role of the Medical Director in the Skilled Nursing Facility. The Conference will be held on June 18-19, 1976 at the Hilton Inn-North, 7007 North High Street (Worthington) Columbus, Ohio.

Inquiries regarding this conference for Medical Directors, Nursing Home Administrators, and Directors of Nursing can be made by calling the OSMA office, (614) 228-6971.

Ohio Medicaid Crisis

Funds for paying for physician services and other providers of care under the Ohio Medicaid program are exhausted for this fiscal year. Committees of the Ohio Legislature are looking for ways to provide additional funding for this financially plagued program. It is estimated, as of May 28, 1976, there were approximately \$28 million of unpaid Medicaid claims in the Ohio Department of Public Welfare. Approximately another \$40 million in unpaid claims will build up between now and the end of this fiscal year if funds are not provided to meet this crisis.

Kwegyir Aggrey, newly appointed Director of the Ohio Department of Public Welfare, has indicated to the OSMA that, assuming no change in State Statutes, funds for the next fiscal year (July 1, 1976) can be used to pay claims incurred this fiscal year.

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Cover by Douglas J. Freeman.



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential

status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

OSMA NEW MEMBERS

The Ohio State Medical Association welcomes the following physicians who joined the society during the month of April 1976. The list indicates the county and city in which each new member is practicing or taking postgraduate work. The support of these physicians for their state organization is appreciated.

ASHLAND (Ashland)
Constance Donley

ASHTABULA (Ashtabula)
Samuel Kerneklia

BROWN (Georgetown)
Gene F. Conway

BUTLER (Hamilton)
Ramon Portales

CUYAHOGA (Cleveland unless noted)

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Bernard L. Kastem
Stephen A. Kollins
John R. Kramer, Jr.
P.K. Unni Kumar
Lai Heung Chang Lee
Sang Joon Lee
David E. Lehtinen
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Avram E. Pearlstein
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Christine A. Quinn
Carr D. Razzano
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Nabila Rizk
Bruce A. Sebek
Jeffrey C. Seiler
Madhusudan T. Sheth
Howard Simon

John F. Steele
Ezra Steiger
Leonora D. Supnet, Aurora
Ronald F. Swanger
Harris C. Taylor
Hermelino V. Tolentino
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Irving De Franco-Veloz
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Allan J. Weinstein
Gary M. Widzer
William T. Wieder
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GEAUGA (Chardon)
Mansukhlal J. Domadia

GREENE (Yellow Springs)
Robert James Scott

HURON (Willard)
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JEFFERSON (Steubenville unless noted)

Marta J. Chaplynsky
Narong Chinakarn
Jae Myung Koh
Ahn Oh Pack, Brilliant
Gene Howard Samuelson
Ranjeet K. Singh
Belen P. Vargas

LUCAS (Toledo)
Avinash S. Deskmukh
John M. Howard

MAHONING (Youngstown unless noted)

Masudur Bhatti
Shantikumar K. Gandhi
Sudershan K. Garg
Paul W. N. Ho
Joungsen Hong, Hubbard
Hyun-Bo Lee, Beloit
Ivan A. Lopez
Jeet Mehta
Asher J. Rabinowitz
Panos P. Zafirides

MEDINA (Medina)
John L. Kuehn
I. Huei Lin

MIAMI (Troy)
Hansa Mukun Kothari

MONTGOMERY (Dayton)
Hassen Mehbod
David P. Nicholson

ROSS (Chillicothe)
Ming-Kong Chen

SANDUSKY (Fremont)
Muhammed Hashim

SUMMIT (Akron unless noted)
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Andrew Di Bartolomeo
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Richard Lee Fawcett
John P. Flanagan, Cuyahoga Falls
Richard S. Golembiewski
Mohammad Colshahi
Eric Lee Jenison
Carl William Keck
Victor J. Louisin
Teresa Maria Matty, Barberton
Harris Musesafer, Cuyahoga Falls
Joseph E. Piroq
David J. Schulak
Gene A. Swanson
Chris A. Van Devere

TRUMBULL (Warren unless noted)

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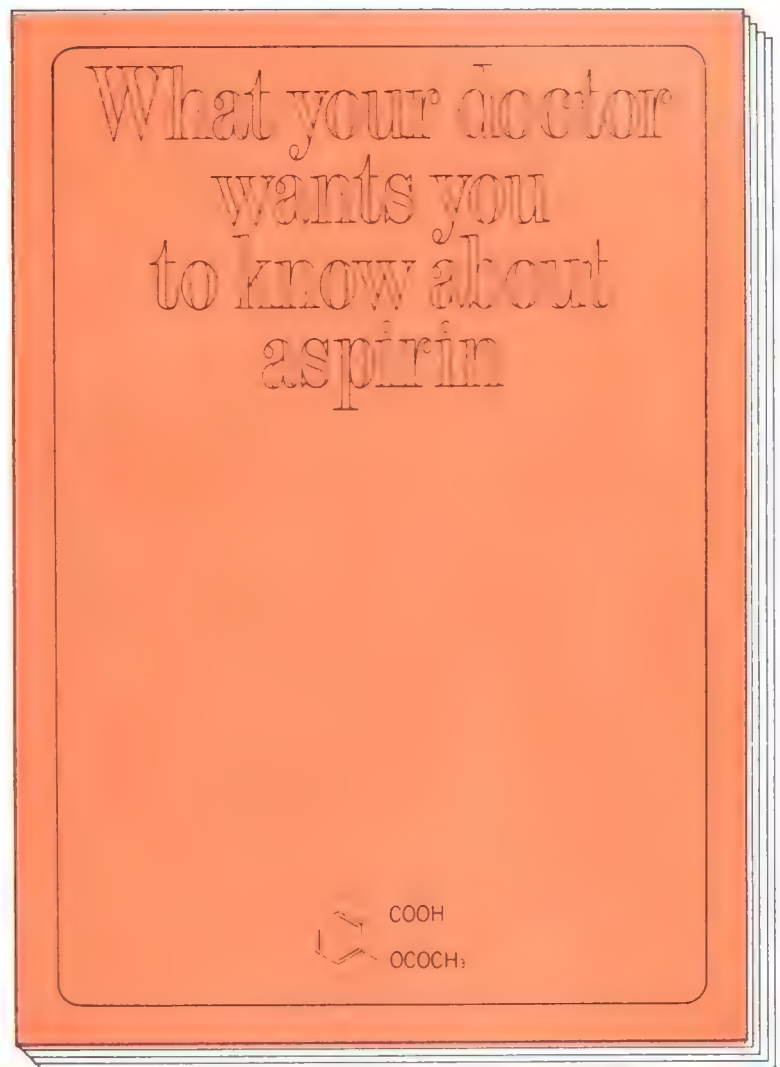
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Moertel and his associates* have suggested that "...if aspirin is recommended with the strong endorsement of the physician, it is acceptable to even the most sophisticated patient."

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*Moertel, C.G., et al: N. Engl. J. Med. 286:813 (Apr. 13) 1972.



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Consumer Rebellion Against Orthodox Medicine At Oberlin—1833



A. CLAIRE SIDALL, M.D.

Presented at the annual meeting of the Ohio Academy of Medical History, March 27, 1976, Granville, Ohio.

In 1833, the Oberlin Colony in Ohio was founded by two missionaries, John J. Shipherd^{1,2} and Philo P. Stewart.^{3,4} They decided that their settlement would be located in Russia township isolated from "sin-infested towns." Only true Christians from New England were to be recruited because they hoped to form a college where ministers and teachers could be trained to go forth and save the wicked West. Complete control of the colony was attempted by requiring all newcomers to sign and abide by a covenant.⁵ The provisions of this agreement included adherence to simplicity in dress, in diet, houses, and furniture. The earliest settlers in Oberlin were farmers and tradesmen; they were considered just as vital to the venture as the faculty members who arrived soon afterwards. In 1850, the name for the school, Oberlin Collegiate Institute, was changed to Oberlin College.

From the beginning, the founders exhibited an unusual interest in health measures. They considered physiology along with Biblical instruction the most important departments in the Institute.⁶ Manual labor was included to provide not only healthful exercise for the students but also to defray their expenses. Shipherd's determination was to find a well qualified man to serve as colony physician and to join the faculty as a teacher of science. His search in the East was rewarded when he was able to recruit James Dascomb who had recently received his Doctor of Medicine degree from Dartmouth College, where he ranked first in a class of 50. In replying to Shipherd's official invitation, Dascomb answered as follows, "... my pecuniary circumstances are such that it would not be consistent for me to engage in your institution unless I could receive a salary equal to four hundred dollars (a year) inclusive of what I might receive from my practice." Apparently these arrangements were satisfactory because Dr. Dascomb and his new bride arrived in Oberlin by a two-horse wagon on May 10, 1834.^{7,8} They were warmly welcomed; but only a few years later the new doctor was surprised and dismayed to hear some of the Oberlin Collegiate Institute leaders speak out against his profession.

The purpose of this report is to trace the development and outcome of this opposition to regular medicine not only in Oberlin but, in brief, outside of Oberlin as well.

Consumer Rebellion Against Orthodox Medicine Outside of Oberlin

The consumer rebellion against orthodox medicine at that time was not an isolated phenomenon confined to any one area. It swept the entire country in the 1800s and brought the prestige of the regular practitioners to the lowest point in the history of the country. The medical profession did not reestablish its present position in society until the last of the 19th and the beginning of the 20th century when medical education was improved and modern medical discoveries were made.

Since the time of Benjamin Rush,⁹ who believed in copious bloodletting, public sentiment had been growing against the universal practice of physicians, prescribing venesection and calomel for almost every disease. Criticism reached the public press from many sources. In 1839, a reader of the *Graham Journal of Health and Longevity* submitted a letter for publication under the heading, "Improprieties in Regular Medical Practice." It read: "Of all the usages, rife among physicians none can be regarded so hurtful and so void of utility as the abominable custom of phlebotomy . . . the result of which is the burial of thousands . . . calomel as well as bloodletting had a part in the death dealing work."¹⁰

Although Jacob Bigelow of Boston pointed out in 1835 that certain diseases were self-limited regardless of treatment,¹¹ most physicians ignored this report and continued to use their old favorite panaceas. However, this attitude should be viewed with some sympathy because the regular practitioners of medicine then possessed no specific medications except quinine for malaria.

The most bitter and relentless attack against orthodox medicine came from Samuel Thomson.¹² At 36 years of age, this poor farmer from Massachusetts could neither read nor write. Through his knowledge of the medicinal properties of herbs, he felt called upon to heal mankind. With the aid of Elias Smith, a Universalist preacher, his system of cure was set forth in a book which sold for \$20. Included in each volume was a diploma which granted the purchaser permission to practice Thomson's method. His crusade was to make every man and woman a practitioner of medicine.¹³ In keeping with the prevailing

spirit of the times, which was to eliminate all restraint in the practice of medicine, he pursued a strategy that would break the so-called monopoly of the regular doctors. He was violently opposed to the use of phlebotomy, calomel, and harsh emetics and cathartics. He, his adherents, and others entered the political field and exerted strong pressure on the various state legislatures to repeal the regulations that prevented anyone from practicing medicine.¹⁴ They achieved success in all but three states.

Although the Thomsonians claimed the following of one-half of the population of Ohio in the early 1800s,¹⁵ they never gained a foothold in Oberlin. This came about because the Oberlin Colony began as a closed society and only those physicians who were invited could settle and practice there. Dr. Dascomb was chosen as Oberlin's first physician not only due to his superior training but also for his favorable personal qualifications. He was a patient man, "hard working, discreet and well balanced, highly esteemed and respected and possessed of sound judgment."¹⁶ It is true that he utilized bloodletting and prescribed calomel but in moderation. His Note Book¹⁶ reveals that he practiced good obstetrics for that time, and it is remarkable that the women in the Oberlin settlement did not hesitate to consult a man for their childbirth.

Two of his obstetric cases are of interest. One was a woman who, after a labor of four hours, exhibited a cervix dilated to the size of a ten cent piece. His record states, "I then bled her to the amount of 12 ounces and after two hours the cervix was dilated to the size of a collar. Pains insufficient. Gave a decoction of 20 grains of ergot. The contractions very soon became very vigorous-child expelled in one hour-placenta in 10 minutes." The labor of another patient was complicated by the retention of the placenta and Dascomb describes his procedure as follows, "The hand was then introduced and after a tedious process the adhesions of the placenta were separated, and it was extracted with moderate hemorrhage."

After two years of general practice at Oberlin, Dr. Dascomb devoted full time to teaching science in the institute. The second physician invited to this village was Dr. Alexander Steele,¹⁷ a graduate with an M.D. degree from Castleton Medical College in Vermont. On February 15, 1836, a committee of R. E. Gillett and Dr. Dascomb wrote to Dr. Steele concerning practice in Oberlin, "We have applications from several physicians who wish to locate in the colony but we have not sufficient evidence that they are the kind of men we need. We are now prepared to give you a cordial invitation to become our physician."¹⁷ This letter makes it clear that the Oberlin community was still a closed society and only those approved by the official body were permitted to join the group.

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Consumer Rebellion (continued)

satisfaction on the part of the general population as elsewhere. It grew out of the collegiate institute leaders' determination to pursue reform regarding every problem of the day, including reform in health.⁶ Asa Mahan, President of Oberlin Collegiate Institute,¹⁸ Charles G. Finney, the famous American Evangelist and Professor of Theology,¹⁹ along with the founders of the colony, Shepherd and Stewart, early espoused the popular physiological reforms of Sylvester Graham. For a time, these same men accepted the new theory of medicine, Orthopathy, as elaborated by Dr. Isaac Jennings. Although both of these new movements incorporated many sound scientific elements yet overenthusiasm carried each of them to advocate measures that came in direct conflict with opinions of regular medicine.

Sylvester Graham, a Presbyterian minister,²⁰ became deeply interested in health during his two bouts of consumption. He elevated the field of health into a religious and moral context and claimed that his ideas conformed to Biblical literature. He moved thousands of his listeners to repent and change their ways toward better hygiene. With an air of authority, he laid down specific rules for all to follow, such as, vegetarian diet, no condiments, adequate exercise, fresh air, abstinence from tea, coffee, alcohol, tobacco,²¹ and severe restrictions on sexual relations.²² For a time, he literally seized the initiative from the regular doctors in the education of the laity concerning personal hygiene and preventive medicine.

His exaggerated claims carried beyond the scientific concepts of the time. He believed that salt was a cause of cancer. He wrote that daily shaving of the beard would shorten a man's life.²¹ He maintained that no disease was absolutely contagious and that, by following his ideas, the so-called contagious diseases could be eliminated.²³ In reference to the dread disease of cholera, he preached that "none is better calculated to prevent cholera than the bread (whole wheat) which I now recommend."²³

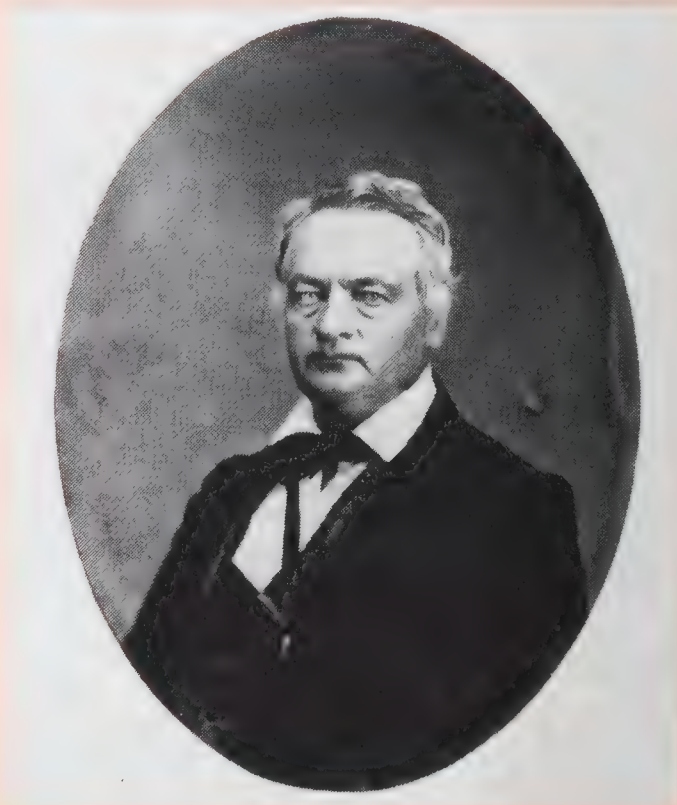
As the Oberlin Collegiate leaders accepted Graham's tenets (all except his advocacy of dancing), they proceeded to impose those rules on the students and to exert pressure on the colonists. At this point the rebellion against the local doctors took concrete form. It appears that Oberlin became more closely associated with Graham's reforms than any other community in the country.

Graham's influence led to the formation of the American Physiological Society in Boston in 1837, and satellite societies followed soon afterward. Oberlin men and women started such organizations locally to study the rules of health and longevity.⁶ Graham boarding houses sprung up, especially in the East.²⁴ Dr. William Alcott,²⁵ first president of the national society was invited to lecture at Oberlin. David Cambell, corresponding secretary of the same society and editor of the *Graham Journal of Health and Longevity*, later came to Oberlin as supervisor of the student dining hall.⁶ This move insured a true Graham menu.

Mr. Willard Sears, a friend of Finney and an Oberlin Trustee, was on the executive committee of the American Physiological Society. Amasa Walker, who later became Professor of Political Economy and a member of the Oberlin Board of Trustees, served as vice president of the Boston Physiological Society.⁶ In 1839 Mahan, President of Oberlin Collegiate Institute, addressed the American Physiological Society on the subject, "Intimate Relations Between Moral, Mental and Physical Law."²⁶

It soon became evident that the extremism of some of the Grahamite views could not be tolerated by Dr. Dascomb and Dr. Steele. Dascomb expressed his feelings in a letter to his family as follows, "I am not entirely pleased with all the 'new measures' respecting the Institute."²⁷ However, he did not carry out his threat to resign.

While Grahamism rode the wave of popularity in Oberlin, a more serious challenge to the local doctors developed when Dr. Isaac Jennings was invited to join the colony in 1839. He was the author of a new medical theory called Orthopathy which means "no medicine" in the treatment of disease.²⁸ Dr. Jennings,^{29,30} born in Connecticut in 1788, studied medicine in the office of Eli Ives, M.D., at New Haven. Later, he was granted an honorary M.D. degree from Yale. Early in his private practice, he undertook the care of a man ill with fever. The patient refused to take any medicine. When Jennings observed that the patient recovered spontaneously, he was much impressed. Later, he announced his discovery that, "Man's physical system possesses within itself the machinery for its own renovation."²⁸ However, this was simply a rediscovery of the well-known observation of



James Dascomb, M.D., Oberlin's first physician.

Hippocrates that nature cures many diseases without the use of medicine.³¹ Jennings was on solid ground when he condemned physicians for using bloodletting and calomel, but he went further and stated that all medicine was harmful. He agreed with Graham in all essentials and in sickness no medicine was necessary.

During his first visit to Oberlin, Jennings lectured to the students on his favorite subject. With a show of confidence and conviction, he described the dramatic case of a young woman afflicted with typhus fever who was cured by the administration of four drops of "aqua fontana pura" every four hours for several days.³²

When Jennings published his first book setting forth his theory of medicine, Professor Charles Finney wrote a testimonial for his friend as follows, "I find myself verging to the conclusion that this must be true."²⁸ In a lecture to the students, Finney declared that the "whole class of physicians who instead of trying to prevent disease . . . go about and give this pill to one man and another to another without knowing whether it will kill or cure."³³ Finney obviously spoke with some hostility toward the medical profession. His attitude no doubt grew out of a past experience during his attack of cholera in New York City in 1832. He later recorded in his Memoirs his honest judgment that the medicine given him at that time by an orthodox physician had caused serious damage to his body.³⁴

John Shipherd also turned away from Dr. Dascomb whom he had so carefully recruited a few years previously. In a letter to his brother, Shipherd made clear his high esteem for Dr. Jennings. He wrote, "His lectures are of far more worth than the advice and medicines of other doctors and I hope his labors of love will bring him needed support. I consider Dr. Jennings and his theory and practice of hygiene as harbingers of the millennium."³⁵ During his travels East, as the money-raising agent of the Institute, Shipherd always sought out a Graham House where he found food that his delicate stomach could tolerate. He dated his lifelong health problems from an accident while a young man. At the age of 17 years, he suffered a serious gastric hemorrhage following the ingestion of saltpeter. This was taken by mistake for epsom salts. His eyes and his stomach were permanently injured. Later in life, he could not forget that after repeated consultations with orthodox doctors, they failed to cure him.¹

Jennings reached the peak of his popularity in Oberlin when he successfully carried Professor Finney through a long siege of typhoid fever without the benefit of any medicine. Thus, it is clear that the rebellion against the regular practitioners in Oberlin was promoted not by the common people as elsewhere in the country, but by a few leaders of the Oberlin Collegiate Institute. The relatively short duration of this rebellion was due to health reforms being carried to an extreme degree which the students and the colonists refused to accept. From the very beginning of requiring a vegetarian diet in the student dining

hall, a group of students insisted on having a meat table. In 1836, the Board of Trustees requested the students to manage their own diet for one year. During that trial period, a student described the great difference in their food. He said, "we have meat as often as four or five days a week."³⁶ Also, there was growing evidence that many local residents were not adhering to the vegetarian restrictions. The Agricultural Committee reported to the college Prudential Committee for March 1839 as follows, "Your committee is unanimous in expressing their high sense of the value of the dung-hill fowl. No flesh perhaps claims so universal devotion as the well fattened yearling cock or pullet."³⁷

Finally, in 1840, the colonists in Oberlin called a public meeting to protest the continuation of the Graham diet for the college students.³⁸ The antivegetarians won the debate. The Prudential Committee then asked for the resignation of David Cambell who had enforced strict Graham rules on the students. Thus came to an end the experimental imposition of Grahamism in this institution.

The enthusiasm for Graham's extremism began to wane about this time all across the country and Professor Finney's change of mind not until 1845, came as an anticlimax. He wrote in the *Evangelist* magazine as follows—

When I first read Graham's work on Physiology and Dietetics, I was deeply interested in it . . . After a while I found myself in complete bondage . . . with respect to diet it is that we shall as far as circumstances permit, prefer those things which are most consistent and conducive to the best physical state of our bodies, not hesitating however for conscience sake to eat such things as are set before us in our journeys.³⁹

At last, all of the people in the Oberlin Colony could approach a meat meal with enjoyment, free from the anxiety of guilt.

As Dr. Steele's practice grew rapidly in volume, it became evident that many local citizens ignored Dr. Jennings's ideas on medical care. The vast majority in the community had turned to Dr. Dascomb and Dr. Steele whom they held in high regard.

When Dr. Jennings started private practice in Oberlin, he prescribed bread pills and colored water as placebos. However, he soon abandoned this pretense and ordered for his patients simply rest, diet, proper bathing and exercise, and he made no charge for this service.⁴⁰ As his practice declined, he made direct verbal attacks against Dr. Dascomb. In the 1860s he announced that it was Dr. Dascomb who influenced the people to have no faith in his theory. He said that the "cloud of prejudice which has been raised in Oberlin on the questions of diet and medicine," has made the minds of Oberlinites, "as impenetrable as the grisly hide of the rhinoceros."⁴¹ Jennings's admission of defeat of his theory marks the end of the rebellion against the orthodox physicians at Oberlin.

Outside of Oberlin, in the country at large, the consumer rebellion against regular medicine continued
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Consumer Rebellion *(continued)*

for over 60 years, during which time the regular practitioners gradually eliminated the old therapy of blood-letting and calomel. During this time, heretical sects in medicine and quacks flourished and took advantage of those people who insisted on freedom from all restraints in the field of medical care.

Fortunately, the Oberlin community escaped the curse of quacks during its early years because it was a closed society and because their doctors, who were invited to join this settlement, were well trained and supplied superior curative medicine. In retrospect, it must be admitted that Grahamism and Dr. Jennings's theory of "no medicine," when stripped of their excesses, taught the early Oberlin settlers good preventive medicine.

References

1. Shipherd E: A Sketch of the Life and Labors of John J. Shipherd, in Shipherd papers, Oberlin College Archives.
2. *Dictionary of American Biography*, New York, Scribner's Sons, 1935, vol 17, pp 111-112.
3. Stewart Mrs EC: *P. P. Stewart, A Worker and A Worker's Friend*, New York, 1873.
4. *Dictionary of American Biography*, New York, Scribner's Sons, 1936, vol 18, pp 11-12.
5. Covenant of Oberlin Colony, photocopy, in Fletcher papers, Box 11, Oberlin College Archives.
6. Fletcher RS: *History of Oberlin College, From Its Foundation Through the Civil War*, Oberlin, 1943, pp 94, 239, 318, 323, 688.
7. Dascomb letter to Shipherd, Shipherd papers, 1833, Box 1, Oberlin College Archives.

8. Mrs. M. P. Dascomb to Home Friends, May 24, 1834, Fairchild JH: *Oberlin, The Colony and The College*, Oberlin, E J Goodrich, 1883, p 329.
9. Binger C: *Revolutionary Doctor*, New York, Norton & Co 1966, p 228.
10. *Graham Journal of Health and Longevity*, Jan 5, 1839, Boston, vol III, pp 416-417.
11. Bigelow J: On Self-limited Diseases, paper delivered before the Boston Society, May 27, 1835.
12. *Dictionary of American Biography*, New York, Scribner's Sons, 1936, vol 18, pp 11, 488-489.
13. *Boston Thomsonian Manual*, Nov 1835, p 8; June 1835 p 14; Nov 15, 1837, p 221.
14. Kaufman M: *Homeopathy in America*, Baltimore, Johns Hopkins Press, 1971, p 54.
15. Waite FC: Thomsonianism in Ohio, in *Ohio Archeological and Historical Quarterly*, Columbus, 1940, vol 49, p 323.
16. James Dascomb Note Book, Oberlin College Archives.
17. James Dascomb to Alexander Steele, File 16/5, Feb 15 1836, Oberlin College Archives.
18. *Dictionary of American Biography*, New York, Scribner's Sons, vol 12, pp 208-209.
19. *Dictionary of American Biography*, New York, Scribner's Sons, pp 394-396.
20. *Dictionary of American Biography*, New York, Scribner's Sons, 1931, vol 7, pp 478-480.
21. Graham S: *Science of Human Life*, Boston, Marsh Capen Lyon and Webb, 1839, vol 2, pp 533, 639.
22. Graham S: *Lecture to Young Men on Chastity*, Boston, George W Light, 1837, p 73.
23. Graham S: *Epidemic Diseases*, Boston, David Cambell, 1838, pp 45, 57.
24. LeDuc TH: *Documents*, New York History, Cooperstown, N Y Historical Society, 1939, vol 20, pp 189-190.
25. *Dictionary of American Biography*, New York, Scribner's Sons, vol 1, pp 142-143.
26. Mahan A: Intimate Relations Between Moral, Mental and Physical Law, in *Graham Journal of Health and Longevity*, Boston & N Y, 1839, vol 3, pp 154-158.
27. James Dascomb letter to family, File 16/5, Oberlin College Archives.
28. Jennings I: *Medical Reform*, Oberlin, Fitch and Jennings, 1847.
29. Orcott S, Beardsley A: *The History of the Old Town Derby Conn. 1642-1880*, Springfield Mass, 1880.
30. Jennings WH: *A Genealogical History of the Jennings Family in England and America*, Columbus O, 1899, p 427.
31. Osler W: *Evolution of Modern Medicine*, New Haven, Yale Univ Press, 1921, p 66.
32. Nancy Prudden to George Prudden, May 16, 1837, Robert Fletcher papers, Box 18, Oberlin College Archives.
33. Davis Prudden to Peter Prudden, Aug 3, 1836, photostat copy, Robert Fletcher papers, Box 18, Oberlin College Archives.
34. Finney CG: *Memoirs*, New York, A S Barnes, 1876, p 320.
35. J J Shipherd to Fayette Shipherd, Oct 16, 1841, typescript copy, Robert Fletcher papers, Box 13, Oberlin College Archives.
36. Nancy and Davis Prudden to George P. Prudden, Apr 8-13, 1837, Robert Fletcher papers, Box 18, Oberlin College Archives.
37. *Agricultural Committee Report, March 1839*, Robert Fletcher papers, Box 2, Oberlin College Archives.
38. Notice dated March 20, 1841, 16/5, Oberlin College Archives.
39. Finney CG: *Oberlin Evangelist*, April 1845.
40. Jameson GC: Historical sketch of medicine in Oberlin. *Ohio State Med J* 33:299-306, 1937.
41. Jennings I: *Tree of Life*, New York, Miller Wood, 1867, pp 50-51.

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TEDRAL[®] SA Sustained Action — CAUTION: Federal law prohibits dispensing without prescription. *Indications:* Tedral SA is indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. It may also be used prophylactically to abort or minimize asthmatic attacks and is of value in managing occasional, seasonal, or perennial asthma. Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage. Tedral SA is an adjunct in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes. *Contraindications:* Sensitivity to any of the ingredients; porphyria. *Warning:* Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING. *Precautions:* Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma. *Adverse Reactions:* Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported. *Dosage:* Tedral SA. *Adults* — (average prophylactic or therapeutic dosage) — one tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Dosage in children under 12* is not recommended because usage has not been established. *Supplied:* Tedral SA. Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in unit dose — package of 10 x 10 strips (N 0047-0231-11). Full information is available on request.



WARNER/CHILCOTT
Division, Warner-Lambert Co
Morris Plains, N.J. 07950

T-GP-52-B/W

COLLEAGUES IN THE NEWS . . .

GEORGE N. BATES, M.D., Toledo, was appointed to the newly created Governor's Advisory Commission on Malpractice. Dr. Bates is President of the OSMA. Also named to the Commission was **JAMES L. HENRY, M.D.**, of Grove City, Past-President of the OSMA. The Commission is to study the effects of the medical insurance plan put into effect last year.

Three physicians were reelected officers of the Board of Ohio Medical Indemnity, Incorporated (OMI). **DWIGHT L. BECKER, M.D.**, will serve as Chairman of the Board. Dr. Becker, a Lima general practitioner, has been a member of OMI's Board of Directors since 1960. **WILLIAM M. WELLS, M.D.**, who first joined the board in 1972, was elected vice-chairman of the board and chairman of the executive committee. Dr. Wells is in general practice in Newark. **JAMES G. ROBERTS, M.D.**, an Akron orthopedist, has been on the OMI board since 1971 and will serve again as secretary.

Four Ohio physicians have been admitted to Fellowship in the American College of Physicians, national medical society representing specialists in internal medicine and related fields. Those honored by the College are **JANET K. BIXEL, M.D.**, Worthington; **JAMES M. GARVEY, JR., M.D.**, Cincinnati; **DAVID L. JACKSON, M.D.**, Cleveland Heights; and **DONALD L. PARKER, M.D.**, Akron.

A. V. BLACK, M.D., Centerville, was recently featured on the television documentary series, "Matter of Life," sponsored by Blue Cross-Blue Shield. The program examined Dr. Black's daily routine and dealt with the cost of physician's care. The show is aimed at acquainting the viewer with some little-known aspects of a doctor's life.

HAROLD J. BOWMAN, M.D., and **THOMAS H. HOOVER, M.D.**, have been elected trustees of the Aultman Hospital Development Foundation. Dr. Bowman was also elected to the executive committee of the Foundation.

JAMES H. CARSON, M.D., Martins Ferry, is one of eight scientists selected to serve on the East Central Ohio Regional Membership Committee of The Ohio Academy of Science. The purpose of the committee is to increase the Academy's membership.

PAUL W. EBERT, M.D., Dover, has been appointed director of medical services for the Timker Company in Canton. In addition to his private practice Dr. Ebert has been medical director for General Electric's Dover Wire Works and plant physician for the Timker Company's New Philadelphia plant.

JOHN W. GUJU, M.D., Youngstown, was awarded the Alan Guttmacher Award for outstanding service from Planned Parenthood of Mahoning Valley, Inc. Dr. Guju has served with the organization for the past 20 years.

COLONEL JOHN J. HALKI, Commander of Wright-Patterson Air Force Base Medical Center, has been appointed as the nonsalaried Assistant Dean for Air Force Affairs at Wright State University School of Medicine. Colonel Halki's appointment represents another major step toward building a strong relationship between the Base Medical Center and the School of Medicine.

CHARLES H. HERNDON, M.D., Cleveland, was named president of the Council of Medical Specialty Societies. Dr. Herndon is Professor and Chairman of Orthopedics at Case Western Reserve University School of Medicine and University Hospitals.

LOUIS D. KACALIEFF, M.D., Medical Director of the Akron Child Guidance Center, has been named Chairman of the Council of Chiefs of Psychiatry for Northeastern Ohio Universities College of Medicine. Dr. Kacalieff held a U.S. Public Health Fellowship in Child Psychiatry at Cleveland Guidance Center and was Chief of the Neuropsychiatric Division, Scott Air Force Base. He has served as Medical Director of the Akron Child Guidance Center since 1955.

JOHN J. KRALIK, M.D., Cleveland, was honored as "man of the year" by the Cathedral Latin Alumni Association for his outstanding work in his profession and for his support of the school. Dr. Kralik is Director of Cardiovascular Surgery at Marymount Hospital.

JOHN O. LINDOWER, M.D., Ph.D., Professor and Chairman of the Department of Pharmacology, Wright State University School of Medicine, has accepted the additional title of Assistant Dean for Curriculum. In his new role, Dr. Lindower will coordinate the work of the school's various curriculum committees.

MORTIMER B. LIPSETT, M.D., Cleveland, will resign as Director of the Cancer Center, Inc. to become Director of the Clinical Center at the National Institutes of Health in Bethesda, Maryland. Dr. Lipsett has been Associate Director of the National Institute of Child Health and Human Development, part of the National Institutes of Health, until becoming Director of the Cancer Center, Inc. He was also Branch Chief of the National Cancer Institute.

RICHARD L. MEILING, M.D., Consulting Medical Editor of *The Journal*, has been elected President of the Ohio Academy of Medical History. Membership in the Academy is open to physicians, scientists, and others interested in Ohio's medical history. Annual dues are \$1. Membership applications should be addressed to Mrs. Kay Barkley, Medical Librarian, Jewish Hospital, Burnet Avenue, Cincinnati 45280.

WILLIAM A. MILLHON, M.D., Columbus, was reelected to the Board of Trustees of the American Society of Internal Medicine during its 20th Annual Meeting held in April. Dr. Millhon is Chairman of the Department of Medicine at Riverside Methodist Hospital and Associate Clinical Professor of The Ohio State University College of Medicine.

Past-President of the Ohio Society of Internal Medicine and member of ASIM's Board of Trustees since 1971, Dr. Millhon has also served as Chairman of the Peer Review Committee, the Research Advisory Committee, the Peer Review Council, and the Patient Care Council. In addition, he was Project Chairman, Region 10, PSRO of Ohio, and Vice-Chairman, Region 10, PSRO Council. He has been Trustee of the Society's Socio-Economic Research and Education Foundation (SEREF) for the past five years.

ANTHONY RUPPERSBERG, JR., M.D., Columbus, was reappointed by Governor James A. Rhodes to the Ohio State Medical Board. Dr. Ruppertsberg is an Assistant Professor at The Ohio State University College of Medicine and is Chairman of the OSMA Committee on Maternal and Mental Health.

ROBERT STRATTON, M.D., Gahanna, has been named Franklin County Health Commissioner to replace Ralph Lach, M.D., who resigned. Dr. Stratton will continue his practice at the Gahanna Clinic.

FRANK VECCHIO, M.D., Cleveland, has been selected to receive the first St. Vincent Charity Hospital Distinguished Surgeon Award. Chief of surgery for 15 years, Dr. Vecchio has served two consecutive terms as the president of the hospital medical staff.

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A. C. Spath, Jr., R. A. Zimmerman
COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: Suite 221, 5241 Southwyck Blvd., (419) 865-5215, R. E. Stallter

Report on Examination of Financial Statements For the Year Ended December 31, 1975

Accountants' Report

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheet of Ohio State Medical Association at December 31, 1975, and the related statements of operation and net worth and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As described in Note 3 to the financial statements, the Association has receivables from a nonprofit corporation of \$75,217 at December 31, 1975. Recoverability of the receivables is dependent upon the successful development and marketing of a peer review system for the medical profession. Because of the aforementioned condition, recoverability of the receivables is not determinable.

As described in Note 7 to the financial statements, during the year the Association and its wholly-owned subsidiary were named as defendants in a legal action which alleges violations of federal and state antitrust laws. Because of the present status of the litigation, the ultimate liability, if any, cannot now be determined.

In our opinion, subject to the effects, if any, on the financial statements of the ultimate resolution of the matters discussed in the preceding paragraphs, the aforementioned financial statements present fairly the financial position of the Ohio State Medical Association at December 31, 1975, and the results of its operations and changes in financial position for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Columbus, Ohio
March 5, 1976

Coopers & Lybrand

Ohio State Medical Association Balance Sheet, December 31, 1975

Assets

Current assets:

Cash		\$289,149
Accounts receivable, less allowance for doubtful accounts of \$160		21,542
Prepaid expenses, including \$80,737 of unamortized pension costs		88,273
Total current assets		398,964

Other assets:

Due from Medical Advances Institute (Note 3)	\$75,217	
Investments:		
General Trust Fund, at cost which approximates market	42,037	
Ohio Medical Indemnity, Inc., at cost (Notes 6 and 7)	56,000	
Other	3,713	176,967

Property and equipment, at cost (Notes 1 and 2):

Land	200,987	
Building	514,020	
Furniture and fixtures	111,643	
Less accumulated depreciation	(72,475)	754,175
		\$1,330,106

Liabilities and Net Worth

Current liabilities:

Accounts payable	\$58,472
Current portion, term debt (Note 2)	90,400
Accrued interest	1,772
Other current liabilities	168,685
Total current liabilities	<u>319,329</u>
Term debt (Note 2)	238,507

Deferred income:

Annual membership dues (Note 1)	\$98,902	
Life membership dues (Note 1)	31,200	
Other	<u>6,873</u>	136,975
Net worth (Notes 7 and 9)		<u>635,295</u>
		<u><u>\$1,330,106</u></u>

(The accompanying notes are an integral part of the financial statements.)

Statement of Operations and Net Worth

For the year ended December 31, 1975

Income:

Membership dues (Note 1)	\$1,214,487
Exhibit fees	22,100
Annual meeting	11,795
Fees for collection of AMA dues	10,968
Interest on savings accounts and certificates of deposit	21,306
General Trust income	8,338
Rental income	12,484
Other	4,024
	<u>1,305,502</u>

Operating expenses:

<i>Ohio State Medical Journal</i> , net, including interest of \$2,034 (Note 8)	\$ 91,795	
Salaries	375,825	
Honorariums and expenses	72,171	
Professional conferences and scientific meetings	90,998	
Committee expenses	23,600	
Public relations	8,181	
Employee benefits, including pension costs of \$70,003 (Notes 1 and 4)	89,661	
Contributions	12,866	
General operating expenses, including interest of \$28,918	<u>313,020</u>	1,078,117
Net income from operations		<u>227,385</u>
Net worth, beginning of year		407,910
Net worth, end of year		<u><u>\$635,295</u></u>

(The accompanying notes are an integral part of the financial statements.)

(continued on page 341)

When **impotence** due to
androgenic deficiency

is driving them apart



Android-5 Buccal
Tabs
Android-10 Oral
Tabs
Android-25 * Oral
Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert * B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

Android-G

Androgen, Estrogen, Vitamins, Minerals

EACH ANDROID-G TABLET CONTAINS:

Methyltestosterone	1.25 mg
Ethinyl Estradiol	0.005 mg
L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg

Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

**Anabolic Stimulant
Increased Muscular Tone
Osteoporosis**

ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057

Write for Literature and Samples



Examination of Financial Statements (continued)

Statement of Changes in Financial Position For the year ended December 31, 1975

Source of funds:	
From operations:	
Net income	\$227,385
Depreciation and amortization not requiring working capital, including \$70,003 relating to pension costs	92,560
Increase in deferred income (net of \$1,350, amortization of life memberships)	7,143
Decrease in unamortized pension cost, net of charges to operations not requiring working capital	28,777
Disposition of equipment, net of accumulated depreciation	47
Other	1,673
	<u>357,585</u>
Application of funds:	
Acquisition of property and equipment	12,489
Increase in General Trust Fund	8,338
Due from Medical Advances Institute	12,500
Repayment of term debt	90,400
	<u>123,727</u>
Increase in working capital	<u>\$233,858</u>
Changes in the components of working capital:	
Increase in current assets:	
Cash	\$163,869
Accounts receivable	6,738
Prepaid expenses and unamortized costs	29,615
	<u>200,222</u>
Increase (decrease) in current liabilities:	
Notes payable to bank	(75,000)
Accounts payable	(50,913)
Current portion, term debt	1,400
Accrued interest	(2,583)
Other current liabilities	93,460
	<u>(33,636)</u>
Increase in working capital	<u>\$233,858</u>

(The accompanying notes are an integral part of the financial statements.)

Notes to the Financial Statements

1. Accounting Policies:

The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.

a. Depreciation:

The Association provides for depreciation on the straight-line and declining-balance methods in amounts adequate to amortize costs over the estimated useful lives of the assets. Depreciation charged to operations during 1975 was \$22,557.

b. Deferred Membership Dues:

Income from annual membership dues is recognized in the calendar year to which they apply. Life membership dues income is recognized over 25 years of active practice of the life membership participants.

(continued on page 342)

Examination of Financial Statements *(continued)*

c. Prepaid Pension Costs:

At the inception of its qualified pension plan during 1969, the Association fully funded all costs of the plan, which amounted to \$386,900. The prepaid costs are being amortized on an approved actuarial method each year, such annual provision consisting of normal cost plus 10% of the frozen initial liability (past service costs), reduced by interest on the unamortized prepaid costs.

2. Term Debt:

Term debt at December 31, 1975 consists of the following:

	Current Maturities	Due After One Year
Unsecured promissory note to bank at 1½% above prime, payable in annual installments of \$75,000, balance due March 15, 1977	\$75,000	\$ 75,000
8% Mortgage loan, payable in monthly installments of \$2,427, including interest, collateralized by land and building, due July 1, 1984	15,400	163,507
	<u>\$90,400</u>	<u>\$238,507</u>

3. Due from Medical Advances Institute:

The Association has advanced \$75,217, primarily noninterest bearing, to Medical Advances Institute (MAI), an Ohio corporation not for profit, to support this organization's development of a peer review system for the medical profession. The recovery of funds advanced to MAI is generally dependent upon the successful development and marketing of the system, which is currently in the developmental stage. The Association strongly believes in the success of the system; however, there has been insufficient operating history and experience to determine the recoverability of the above amount.

4. Pension Plan:

The Association has a salaried employees' pension plan covering substantially all of its employees. (The Association funded the entire cost of the plan at its inception) (see Note 1). The total pension expense for the year was \$70,003, which included normal costs of \$42,465 and past service costs of \$34,200, reduced by interest of \$6,662 on the unamortized prepaid pension costs. At December 31, 1975, the actuarially computed value of vested benefits exceeded plan assets by \$39,400.

The Association is currently in the process of amending its pension plan in compliance with the Employee Retirement Income Security Act of 1974 (ERISA); and, as of December 31, 1975, it has been actuarially determined that the effect of ERISA on pension costs approximates \$6,000, applicable to normal costs only.

5. Leases:

The minimum rental commitments of the Association under all noncancelable leases were as follows at December 31, 1975:

	1976	1977	1978
Equipment	\$11,460		
Automobiles	7,142	\$3,968	\$1,974
	<u>\$18,602</u>	<u>\$3,968</u>	<u>\$1,974</u>

Rental expense under these and similar leases aggregated \$31,544 during 1975.

6. Investment—Ohio Medical Indemnity, Inc.:

The Association owns 100% of the outstanding common stock, 8,000 shares, of Ohio Medical Indemnity, Inc. purchased at a cost of \$56,000. The Board of Directors of Ohio Medical Indemnity, Inc. (Blue Shield) is prohibited from declaring or paying any cash dividends upon such common shares of stock of the Company. In the event of liquidation of the Company, the shareholder (Ohio State Medical Association) shall be paid a sum equal to the price paid for such shares, \$56,000. The Company, having an equity of \$37,135,000 at December 31, 1975, shall at liquidation distribute its remaining assets to the Association, or its successor organization, to be used solely and exclusively for medical research, medical education, or the development and establishment of medical care plans.

7. **Contingent Liability:**

The Association and its wholly-owned subsidiary, Ohio Medical Indemnity, Inc. (OMI), are parties to a civil action which alleges violations of federal and state antitrust laws resulting from monopolistic practices. The plaintiff seeks treble damages under the federal antitrust laws or double damages under state antitrust laws and costs of suit against OMI, and divestiture of OMI by the Association.

The Association is vigorously defending the action; however, it is not possible to determine the ultimate outcome of the litigation at this time.

8. *The Ohio State Medical Journal:*

The income and expenses applicable to the operations of *The Ohio State Medical Journal* are as follows:

Income:

Advertising (net of \$9,337 commissions and \$831 cash discounts)	\$ 63,476
Subscriptions received from nonmembers	1,033
Membership subscriptions, allocated at \$4.50 per member's dues (included in membership dues in the Statement of Operations and Net Worth)	47,250
	<u>111,759</u>

Expenses:

Salaries and payroll taxes	\$ 41,872	
Printing, postage, stationery, supplies, illustrations, engravings, and consulting services	100,214	
Building expenses, depreciation and other	14,218	156,304
Excess of expenses over income, <i>The Ohio State Medical Journal</i>		<u>\$ 44,545</u>

9. **Exemption—Federal Taxes on Income:**

The Ohio State Medical Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code.

New from Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®



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*Additional information available to the profession
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*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate
equivalent to 300 mg. fenoprofen.

6000-1

OSU Cancer Research Center Receives National Designation

Ohio State University's Cancer Research Center has received designation by the National Cancer Institute as a Comprehensive Cancer Research and Demonstration Center. It becomes the 18th in a nationwide network authorized by the National Cancer Act of 1971. The center will serve Ohio, West Virginia, eastern Kentucky, and western Pennsylvania, an area with a population of 18 million people.

The comprehensive centers conduct a broad range of basic and clinical cancer research and related training, and develop and demonstrate the best methods of cancer prevention, diagnosis, treatment, and rehabilitation. Current clinical research of the Ohio State center includes immunotherapy of lung cancer and leukemia, treatment of brain tumors, and studies of potential anticancer agents.

Dr. David S. Yohn, an internationally known virologist, is director of the center. He called the official designation "a tribute to nearly seven years of dedication on the part of more than 400 individuals involved in the cancer effort at Ohio State." He also noted that the center "reflects the full commitment to development of the center by the university administration."

Dr. Yohn cited the assistance of Ohio's U.S. Senators Robert Taft and John Glenn and Columbus-area U.S. Representatives Chalmers Wylie and Samuel Devine in securing the designation.

Rural Health Grants Offered

HEW has announced the availability of grants to foster more effective delivery of health services in rural areas. Under the Rural Health Initiative (RHI) program authorized by certain sections of the Public Health Services Act, grants will serve to promote integrated health systems in rural areas, using new approaches which will combine, coordinate and strengthen health services delivery resources in such areas.

The objective of the grant program is to encourage applicants and grantees to devise models for the eventual designing, implementation and evaluation of health delivery systems in rural areas. Focus of the grants will be on the step-by-step building of primary health care capabilities, along with providing a broad range of basic personal health care services. The examples of models listed in the March *Federal Register* provide for primary care delivery and emphasize group practice as the mode of delivery. They include:

Type 1: Small Group Practice Settings — possibly consisting of 3-5 primary care physicians, servicing a minimum patient population of

7-10,000 persons; patient would be located less than 45 minutes from the center.

Type 2: Small Group Practice Setting with Satellite — this model would provide a remote entry point and follow-up capability to the small group practice setting; the satellite might be staffed by 1 or 2 nurse practitioners functioning in an area where there is a population of 1-3,000 persons.

Type 3: Multi-County Model — a basic small group practice would be a nucleus in any area where there are dispersed population groupings.

Physicians Top Source of Health Care According to Poll

According to a recent survey by Louis Harris, people view physicians more favorably than all other sources of their health care. Topping the 15 categories surveyed are medical specialists, viewed favorably by 83 percent of the public and unfavorably by only 9 percent.

Confidence in general practitioners has risen from 72 percent favorable-19 percent unfavorable in 1968 to 81-16 in 1976.

Hospitals in general got a 70 percent favorable 27 percent unfavorable rating in the poll, which was conducted for the Federation of American Hospitals.

The Harris survey also shows that the public considers higher malpractice insurance premiums one of the five major causes of climbing medical and hospital costs — along with increases in nurses' salaries, physicians' fees, office overhead, and drug costs.

Medicine was rated the most trustworthy profession in a survey by Chilton Research Services. In another survey, more than eight of ten people interviewed by *Roper Reports* said they are "very satisfied" or "fairly well satisfied" with both the quality and availability of their medical care.

AMA-ERF Loans \$5 Million Plus

AMA-ERF granted loans totaling \$5,259,800 to 3,737 medical students, interns and residents through the AMA Education and Research Foundation Loan Guarantee Program during 1975. It was the biggest year for the program since 1966. Since the Loan Guarantee Program started in 1962, AMA-ERF has guaranteed 58,936 loans totaling \$69,368,098. AMA-ERF also awarded grants totaling \$1,275,000 to U.S. and Canadian medical schools. The funds were contributed last year by physicians, AMA Auxiliary, medical societies and other sources. Funds designated for Canadian schools were contributed specifically for those schools.

(continued on page 355)



Take the fastest route

Sublingual ERGOMAR® Tablets

(ergotamine tartrate, 2 mg.)

Sublingual Ergomar Tablets are fast because they take a shortcut to the headache via absorption into the sublingual and buccal blood vessels. They begin to act in 30 to 60 seconds.

"The basic principle of all abortive therapy is that it be administered as speedily as possible in order to abort the head pain."¹

Sublingual Ergomar Tablets are convenient because the patient can take them anywhere, anytime, doesn't even need a glass of water.

Sublingual Ergomar Tablets produce less risk of GI upset . . . because they bypass the alimentary tract, reducing the

The fastest,
most convenient way to
abort migraine
and cluster headaches

potential of further distress to migraine patients whose associated symptoms include nausea." Ergotamine tartrate

in a micronized saliva-soluble form (Ergomar) has been used in our clinic on 334 patients . . . It has all the advantages of the oral form of administration because of its ease and convenience of administration without the slower action and nauseating potential . . ."¹

Available!

Information on vascular headaches for you and your patients.
Please send me

☐ Proceedings of the
Vascular Headache
Symposium (Printed)

Patient Information Booklets ☐

☐ Reprint of Abortive Therapy
for Vascular Headaches
(Consultant 16:156-165, 1976)

Trial Supply of Sublingual
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1. Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976. See reverse side for prescribing information.



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ERGOMAR[®] (ergotamine tartrate)

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Precautions and Contraindications: Avoid prolonged administration or dosage in excess of that recommended because of the danger of ergotism and gangrene. Contraindicated in sepsis, occlusive vascular disease (thromboangiitis obliterans, luetic arteritis, severe arteriosclerosis, coronary artery disease, thrombophlebitis, Raynaud's disease), hepatic disease, renal disease, severe pruritus, and pregnancy.

Side Effects: No serious complications have been reported from the use of Ergomar (ergotamine tartrate) in the

The fastest,
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of migraine
or cluster headaches

absence of contraindications and in recommended dosages. Unpleasant side effects which may occur include nausea and vomiting, weakness in the legs, muscle pain in the extremities, numbness and tingling of fingers and toes, precordial distress and pain and transient tachycardia or bradycardia. Localized edema and itching may occur in the rare sensitive patient. Side effects are usually not such as to necessitate interruption of therapy.

Administration and Dosage: All efforts should be made to initiate therapy as soon as

possible after the first symptoms of the attack are noted, since success is proportional to rapidity of treatment, and lower dosages will be effective.

At the first sign of an attack, or to relieve the symptoms of the full-blown attack, one tablet is placed under the tongue. Another tablet should be taken at

half-hourly intervals thereafter, if necessary, but dosage must not exceed three tablets in any 24-hour period. Limit dosage to not more than 10 mg. in any one week.

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April 28, 1976

The meeting was called to order at 10:00 AM by President Lieber.

Those present were: Drs. Maurice F. Lieber, Canton; George N. Bates, Toledo; James L. Henry, Grove City; William M. Wells, Newark; Stephen P. Hogg, Cincinnati; C. Douglass Ford, Toledo; John J. Gaughan, Cleveland; Robert E. Rinderknecht, Dover; Richard E. Hartle, Lancaster; Thomas W. Morgan, Gallipolis; J. Hutchison Williams, Columbus; Robert G. Thomas, Elyria; James C. McLarnan, Mt. Vernon; Oscar W. Clarke, Gallipolis; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mulgrew, Freeman, Mrs. Wisse, Mrs. Dodson, Ms. Doll and Mrs. Jacobson, of the OSMA Staff.

The minutes of the March 13-14, 1976, meeting of the Council were approved.

The minutes of the April 21, 1976, joint meeting of the Council Fee Review Committee and the Ad Hoc Committee to Study Complaint Procedures were presented by Mr. Page.

The Council accepted the minutes and approved the following two-part policy:

1) non-participation at this time in the review of any disputes among physicians, patients and/or third parties, except those arising out of issues such as utilization of physician's services, medical necessity and appropriateness of medical care and similar complaints, and

2) resumption of fee review activities when future legal and other developments make it appropriate to do so.

The change of the name of the "Council Fee Review Committee" to the "Medical Services Review Committee" was approved.

STATEMENT OF POLICY ON FEE REVIEW

The Council then voted to accept (Dr. Gaughan dissenting) a document summarizing the concepts and events which led to the Council action and adopted an interim policy that "the Ohio State Medical Association will explore and develop the implementation of alternative methods to renew this public service and to deal with disputes among patients, third parties and physicians."

AUDITING AND APPROPRIATIONS COMMITTEE

The minutes of the April 27, 1976, meeting of the Committee on Auditing and Appropriations were presented by Dr. Thomas.

The minutes included a summary of the fiscal status of the Association as presented, in person, by Mr. Ben Minutilli, Manager, Coopers and Lybrand.

The minutes were approved with a minor amendment, removing restrictions on the number of staff executives traveling together on private aircraft.

INFLUENZA IMMUNIZATION REPORT

Dr. Lieber discussed the report on "Swine Influenza" immunization from Richard L. Meiling, M.D., who represented the Association at a meeting held April 2, 1976, at the Center for Disease Control (HEW), Atlanta. The report had previously been forwarded to members of the Council.

By official action, the Council thanked Dr. Meiling for representing the Association and for the excellence of his report.

Possible liability problems for physicians administering the "Swine Influenza" vaccine in mass programs were discussed and the matter was referred to the Committee on Environmental and Public Health for study.

COMMUNICATION FROM DR. SMITHSON

The President read a letter dated April 22, 1976, from John C. Smithson, M.D., Third District Councilor, announcing that he would not be a candidate for that position for another term, due to the change of the location of his practice to another state.

The Council expressed thanks and appreciation to Dr. Smithson for his diligence as a member of the Council and several related committees.

PROFESSIONAL LIABILITY RESEARCH PROGRAM

Mr. Rader, as secretary to the Task Force on Professional Liability, discussed the Association's Professional Liability Research Program and the solicitation for funds to make implementation possible.

Mr. Edgar outlined suggestions for the public information aspects of the Research Program. These were referred to the Auditing and Appropriations Committee and to the Legal Counsel.

OFMC

Dr. Thomas, as chairman of the Ad Hoc Committee to survey the Ohio Foundation for Medical Care, presented a progress report of the study.

A five-page "working document" prepared by MAI containing a "Policy Statement on Research Development and Implementation of Peer Review Programs and Development of Health Care Systems" was delivered to the Council and referred to the Ad Hoc Committee.

(continued on page 348)

CME PROGRAM AND THE MEDICAL BOARD

The Council studied a communication dated March 11, 1976, from Sanford Press, M.D., President of the Ohio State Medical Board, announcing that the Board had at its February 11, 1976, meeting accepted and approved the report of the Medical Board's Committee on Continuing Medical Education.

The report outlined the following:

1. Since Section 4731.281(A), Revised Code, indicates that the applicant shall submit satisfactory evidence of completion of 150 hours of continuing medical education to the Medical Board, it is the Board's responsibility to determine the sufficiency of such evidence.

2. Before renewal, a physician must sign a statement that under penalty of suspension of his or her license, he or she has completed the 150 hour educational requirement and has kept adequate and accurate records thereof.

3. The physician's log and records shall be available to an agent of the Medical Board for inspection.

4. The physician is to submit to the Medical Board a list disclosing how he or she has accumulated the required hours. This list must reveal programs, places, dates, and hours of education in all categories. The Board may require that such lists be submitted periodically during the three year period to lessen administrative workload.

5. The Ohio State Medical Association Commission on Medical Education's proposal for implementation of Section 4731.281(A), dated November 3, 1975, is acceptable to the Medical Board provided that, for purposes of renewal, the Board will recognize two categories of continuing medical education rather than six. The first such category would be that specified as category 1 in the Commission's proposal. A minimum of 60 hours during the three year period must be from this category. The Board's second category would include categories 2 through 6 as specified in the Commission's proposal. This change in the number of educational categories reported to the Medical Board would both reduce complication for the applying physician and promote administrative efficiency for the Board.

The Council voted to **approve** the following communication to the Board:

As a result of your letter of March 11, 1976, the Ohio State Medical Association herein certifies a program of continuing medical education to replace the program certified by the Ohio State Medical Association on February 4, 1976.

This certification is exactly the same as the previous program certified with two exceptions:

1. The State Medical Board's Continuing Medical Education program will recognize only two categories of continuing medical education instead of the six categories originally proposed by the OSMA. The first such category will be that specified as Category 1 in the OSMA previous proposal. A minimum of 60 hours during the three-year period must be from this category. The program's second category will include categories two through six as specified in the previous OSMA proposal. This will permit the physician to accumulate a maximum of 90 hours in any of the original two through six categories for the purpose of meeting the program's second category.

2. The OSMA is certifying this program only for a three-year period (January 1, 1977, through December 31, 1979). This is to allow for assessment of the CME program and to possibly provide for the future use of the original proposal categories two through six.

(continued on page 350)

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Before prescribing, please consult complete product information, a summary of which follows:

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

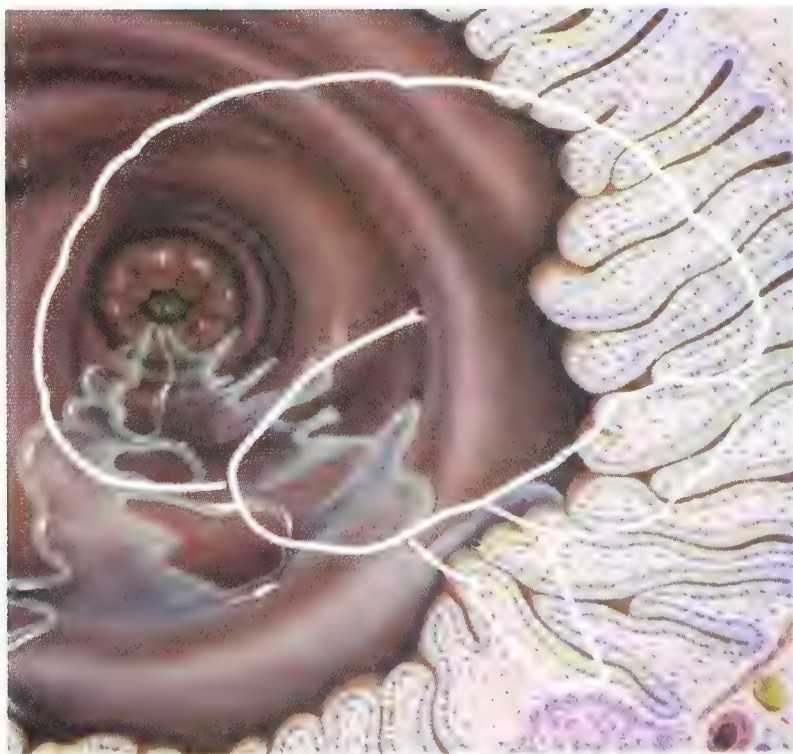


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* This drug has been evaluated as possibly effective for this indication. Please see
preceding page for brief summary of product information.

The OSMA sincerely hopes that the Medical Board will see fit to quickly approve this second certification. It is imperative that both the OSMA and the Medical Board begin now to publicize the guidelines to be used to meet the requirements of the state law. As it is, we are left with only a few months within which to educate a very large number of physicians.

ENDORSEMENT OF DR. DORSEY

The Council voted to endorse the appointment of Richard Dorsey, M.D., Cincinnati, to the National Advisory Committee of the National Institute of Mental Health.

MEDICAID

Mr. Gillen reported to the Council on current developments in Ohio's Medicaid program. The report was accepted.

GROUP TERM LIFE PLAN G 2700A

The Council approved a change in the master contract of OSMA Group Term Life Insurance Plan G



Left to Right: Jerry L. Hammon, M.D., AMA Delegate and Oscar W. Clarke, M.D., AMA Delegate and Delegation Co-chairman.

2700A (Corporate Employees) to permit Turner and Shepard, the administrator, to tailor a program for groups of over 25 individuals.

STATE LEGISLATION

Mr. Rader reported on the passage of H.B. 663, the Physician's Assistant Bill.

PHYSICIAN EFFECTIVENESS PROGRAM

Mr. Clinger reported that physicians participating in a liaison capacity have requested a legal opinion regarding possible litigation against them by "sick" physicians. The Council recommended that legal counsel consider this matter.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page
Executive Director



Left to Right: Thomas W. Morgan, M.D., Ninth District Councilor, and D. Brent Mulgrew, OSMA Assistant Director of State Legislation.



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PHYSICIAN AND HOSPITAL EQUIPMENT

obituaries

Joseph J. Brumbaugh, M.D., Canton; Ohio State University College of Medicine, 1932; age 72; died March 13, 1975; member OSMA and AMA.

Ivor G. Clark, M.D., Columbus; University of Pennsylvania College of Medicine, 1910; age 89; died August 1, 1975; member OSMA and AMA.

Robert R. Crawford, M.D., Mansfield; University of Chicago, Pritzker-School of Medicine, Chicago, 1935; age 70; died March 14; member OSMA and AMA.

Robert Distelhorst, M.D., Richwood; Ohio State University College of Medicine; age 56; died March 16; member OSMA.

Karl D. Figley, M.D., Toledo; Jefferson Medical College of Thomas Jefferson University, 1913; age 89; died March 31; member OSMA and AMA.

Harold Hathhorn, M.D., Belleair, Florida; Ohio State University School of Medicine; age 75; died March 6; member OSMA and AMA.

Saul H. Makman, M.D., Cleveland; Western Reserve University, School of Medicine, 1922; age 77; died March 27.

Link M. Murphy, M.D., Columbus; Ohio State University College of Medicine, 1919; age 82; died March 2; member OSMA and AMA.

Kmalakama Reddy, M.D., Warren; Guntur Medical College Andhra University, Andra, India, 1963; age 35; died March 14; member OSMA and AMA.

David E. Richards, M.D., Cleveland; Case Western University School of Medicine, 1967; age 35; died March 1; member OSMA.

Frank P. Solando, M.D., Palermo Sicily, Italy; Facolta di Medicina Chirurgia dell University, Palermo, Italy, 1923; died April; member OSMA and AMA.

Tito S. Villegas, M.D., Elyria; College of Medicine, University of Philippines, Manila, 1962; age 39; died March 27; member OSMA and AMA.

George F. Weber, M.D., Delphos; University of Louisville School of Medicine, Louisville, 1935; age 68; died March 25; member OSMA and AMA.

Kurt Weidenthal, M.D., Hudson; Eclectic Medical College, Cincinnati, 1928; age 72; died March 22; member OSMA and AMA.

Harold C. Wise, M.D., Cleveland; Creighton University School of Medicine, Omaha, Nebraska, 1923; age 79; died March 30.

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Building the PACs

A curious phenomenon of recent years has been the organization of a lot of political action committees, and then the immediate dormancy of many of them.

In all, there are approximately 450 PACs, many organized by labor groups, and more than 200 formed by corporations.

A surprising number of these have given themselves a name, and then simply marked time, notes Al Pross, director of CALPAC, the California Medical Political Action Committee.

In politics, a decision to do nothing can be the most dangerous move of all.

Speaking to the AMPAC Public Affairs Workshop in Washington, D.C., Pross noted that state medical PACs have only hit their stride in organizing in the past five years or so. They have a good record, however, of actively supporting qualified candidates. At least 20 state medical PACs are among the top 50 such groups in the nation in candidate support.

It is a good thing they are, because the opponents of American medicine are putting plenty of support behind their candidates.

Medical PACs will grow, Pross predicted, but they still suffer from anemic support by considerable numbers of physicians. Sending dues to PACs has something less than wholehearted support, he said.

In addition, Pross said, a new sense of cooperation is needed between state medical PACs. When the race at home is hopeless, when the local candidate hasn't a chance, then the support is better given to another candidate — perhaps in another state, he suggested.

Pross cited CALPAC's recent support of senate candidacies in New Hampshire and Nevada, and of a congressional candidate in New York. Two out of the three races were lost, but it was worth the gamble in these close contests, he said.

In urging on the political troops of medicine, Pross was telling them that it isn't enough simply to organize. It isn't enough simply to organize and to support a candidate, however lost the cause.

To be truly effective in shaping decisions that affect medicine, American physicians must continue to organize, to work and to contribute. They must build a new sense of mutual cooperation as well, a cooperation that will ensure a rational medical system in the nation.

(Reprinted from *American Medical News*, April 26, 1976)



Ohio physicians are pictured at a recent OMPAC workshop for development of candidate support committee. Top (left to right): Ray W. Gifford, Jr., M.D., OMPAC Vice-Chairman; H. William Porterfield, M.D., OMPAC Chairman; and Maurice F. Lieber, M.D., OSMA Past-President. Bottom: W. J. Lewis, Board Member of OMPAC and AMPAC.

J. Celebrezze, Jr., (D-Cleveland), currently a member of the Ohio Senate, is running for his first term in the U.S. Congress.

Representative Ashbrook received the OMPAC contribution from Robert S. Young, M.D., of Johnstown. Ray W. Gifford, Jr., M.D., a member of the OMPAC Board, made the presentation to Senator Celebrezze.

These contributions are good examples of the purpose of OMPAC: elect people who will promote quality health care in the U.S. regardless of political affiliation. OMPAC funds support Democrats, Republicans, and Independents. Contributions represent physician concern about legislation which could lead to the destruction of the fee-for-service concept, the physician-patient relationship, the quality of health care, and the like. In addition, many physicians and their families become personally involved in the campaigns of those who support quality medical care.

Ohio physicians interested in contributing money and/or time in the coming campaigns may contact their county society secretary or treasurer; or OMPAC dues in the amount of \$35 may be sent directly to the Ohio Medical Political Action Committee, P.O. Box 5617, Columbus, Ohio 43221.

(continued on page 355)

OMPAC Funds to Ohioans

The Ohio Medical Political Action Committee (OMPAC) has contributed to the campaign efforts of two Ohioans seeking seats in the U.S. House of Representatives. John M. Ashbrook (R-District 17) is campaigning for reelection to the U.S. House, while Anthony

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Realistic Note: MDs' Dues Should Be Much Higher

Let's try to put into perspective the new changes in our dues structure — national, state, and county.

Confrontation with government cannot be accomplished on the local level. The state medical society must correlate and represent us in the state legislature. Deliberations must then pass to the national level carried by state delegations for input into federal legislation. The final message is presented by our top professional stature — the AMA president, the executive vice president, the chairman of the Board of Trustees — with the important support of staff who maintain government liaison.

When necessary, the profession may bring suit against specific factions as a course of effective action.

When suit was filed by the AMA against HEW a year ago regarding imposition of unacceptable utilization review policies upon the medical profession, the cost to bring suit exceeded \$100,000. The AMA won the suit. Others must follow when indicated, and we will lose some. This is expensive.

The constitution and bylaws of the state and county medical societies specify that membership in one is contingent upon membership in the other. This not only provides unification of expression but by virtue of its group is able to inexpensively provide benefits of insurance on the life, disability, overhead expenses, Blue Cross/Blue Shield and other programs not otherwise available.

Plainly, if one should choose not to retain membership in the state medical society, he would lose his membership in the county medical society and his insurance programs thereby declared null and void.

Should one choose, however, not to maintain AMA membership, he may retain membership in the state and county medical societies. To do this, however, cuts off an important financial contribution to the national organization being supported by his colleagues, many of whom pay the dues as well as contribute time and effort in making the AMA function.

Let's make a few comparisons of cost in other counties. The package of AMA, state, and county, with MDPAC contribution, is \$555 in Wayne County; in St. Joseph County, \$580; Delta County, \$560; Branch County, \$560; Genessee County, \$618; Muskegon County, \$785. Other counties may range from \$25-\$50 less than Wayne County.*

Let's also look for a moment at a low-scale wage earner working for one of our automotive corporations. At the bottom of the ladder, a worker contributes \$10 per week to the UAW, or \$520 per year.

While medical societies are not unions, the comparison between the factory workers' dues and the physicians' is interesting and something to think about, especially when respective incomes are considered.

In conclusion, to be more realistic, our professional dues should probably be much more — in order to provide more expert staff to assume responsibilities now served by harried physicians. Adequate funding would

insure the ability to meet contingencies when they occur, rather than delay until our membership grabbles and grumbles over assessments and minor dues increases and funds become available only after the issue is dead in the water.

James C. Danforth, Jr., M.D.
Michigan

*(EDITOR'S NOTE: Ohio examples of the package of AMA, state, and county dues are \$450 in Belmont, \$490 Butler, \$475 Clark, \$525 Cuyahoga, \$425 Geauga, \$595 Lucas, \$500 Mahoning, \$545 Montgomery, \$465 Miami, and \$435 Portage Counties, Ohio.)

(Reprinted from *America Medical News*, April 26, 1976)

News

Suit Challenges P.L. 93-641

North Carolina filed suit April 27 against HEW challenging the Health Planning Act, P.L. 93-641. Filed in the U.S. District Court for the Eastern District of North Carolina, the suit challenges the constitutionality of the act and whether HEW has the authority to force a state to amend its constitution to allow for a certification-of-need act or risk the loss of federal funds for public health programs.

In 1973, the North Carolina Supreme Court ruled as unconstitutional a similar certification-of-need law. The suit alleges that the act "infringes on the integrity of the state." The announcement of the suit from the State Attorney General's office said that, as a penalty, "The withholding of federal funds would seriously jeopardize public health programs in our state."

The suit is supported by both the North Carolina State Medical Society and the American Medical Association.

House Staff Viewed as Students

The NLRB dismissed petitions from two more house staff associations seeking recognition as collective bargaining groups. In a decision announced April 25, the National Labor Relations Board dismissed a petition from the house staff association at St. Clare's Hospital and Health Center, New York City, which was seeking to represent the hospital's medical residents. On April 28, the Board announced its rejection of a similar petition from the house staff association of the University of Chicago Hospitals and Clinics, which was seeking to represent interns and residents.

Both decisions followed the reasoning set forth in the landmark case involving Cedars-Sinai Medical Center, Los Angeles (see March 26 *Hospital Week*), in which the Board said interns, residents, and clinical fellows are primarily students and, therefore, not employees entitled to protection under the National Labor Relations Act.

Crossing County Lines

Tuscarawas Medical Society Honors Rep. William Hinig

Tuscarawas County Medical Society recently honored State Representative William E. Hinig for his efforts on behalf of the physician during the 111th General Assembly. Carlos J. Torrent, M.D., President of the Tuscarawas County Medical Society, presented Representative Hinig with a plaque which read in part: "With dedication and much hard work Representative Hinig was able to achieve and maintain many important provisions in H.B. 682 calling for major legal reforms . . . the Tuscarawas County Medical Society salute(s) and honor(s) (him) for his long service to his community and to the medical profession."

Representative Hinig also received a plaque from the OSMA in appreciation of his efforts in dealing with the malpractice situation. Maurice F. Lieber, M.D., President of the OSMA, made this presentation.



Knox County Focuses on Family Planning Clinic



Cincinnati Sponsors Annual Cancer Symposium



Toledo Discusses HMOs



(continued on page 360)

The Council of the Ohio State Medical Association met at 8:30 AM, May 13, 1976, at Stouffer's Cincinnati Inn.

Those present were: All members of the Council; James L. Henry, M.D., Grove City, a Past President; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Freeman, Mrs. Wisse, Mrs. Dodson, Ms. Doll and Mrs. Jacobson, of the OSMA Staff.

The President introduced the following newly elected Councilors: Stewart B. Dunsker, M.D., Cincinnati, First District; Alford C. Diller, M.D., Convoy, Third District; and S. Baird Pfahl, Jr., M.D., Sandusky, Eleventh District. Dr. Wells was acknowledged as the new President-Elect, and Dr. Thomas as the Secretary-Treasurer.

The minutes of the April 28, 1976, meeting of the Council were approved.

The Council voted to move cautiously with regard to the April 28, 1976, action on medical services review (Drs. Ford and Morgan dissenting).

The staff and Legal Counsel were instructed to transmit information on the action to the county medical societies and to the members, and to give assistance to members of the Council in their contacts with the leaders in the Councilor districts with regard to this subject.

SPECIAL COMMITTEES

Appointments to special committees for 1976-1977 were presented by Dr. Bates and were confirmed by the Council.

PROFESSIONAL LIABILITY

The minutes of the May 11, 1976, meeting of the OSMA Task Force on Professional Liability were presented by Dr. Henry, and were accepted.

The Council suggested that an "invoice" be sent with the next solicitation letter.

INFLUENZA VACCINATION PROGRAM

The Council received a report dated May 5, 1976, from Dr. Richard L. Meiling, concerning the "Ohio Program of Mass Immunization by Vaccination of Influenza Killer Virus." Dr. Meiling represented the OSMA at a meeting held that date, called by Dr. John Ackerman, Ohio Director of Health.

The Council voted to authorize the President to appoint an Ad Hoc Committee of the Council, and

others as he may select, with regard to the "Influenza Program."

In addition, the Council expressed the desire of the OSMA to help supply the manpower for the administration of the influenza vaccine, provided, however, that a satisfactory relationship between the physicians recruited for the program and the local health departments may be established to minimize the professional liability exposure of those physicians who volunteer (Dr. Pfahl dissenting).

MEDICAID

Mr. Gillen reported on the week's developments in the financial crisis in the Medicaid program of the Ohio Department of Welfare.

DR. HENRY COMMENDED

The Council adjourned after expressing its commendation to Dr. Henry for his many years of productive service on the Council.

ATTEST: Hart F. Page
Executive Director



Left to Right: James E. Pohlman, OSMA Legal Counsel, and Hart F. Page, OSMA Executive Director.

EDITOR'S NOTE: The Journal apologizes for an error in the article "Informed Consent: The Doctor's Dilemma & H.B. 682" which appears on page 210 of Volume 72, Number 4. The columns on page 212 of the article should be reversed.

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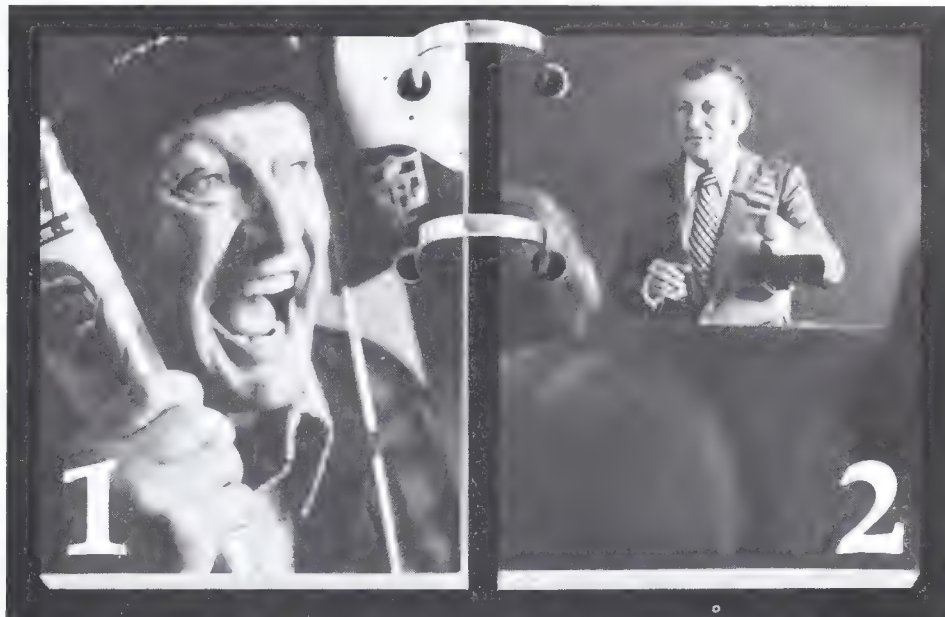
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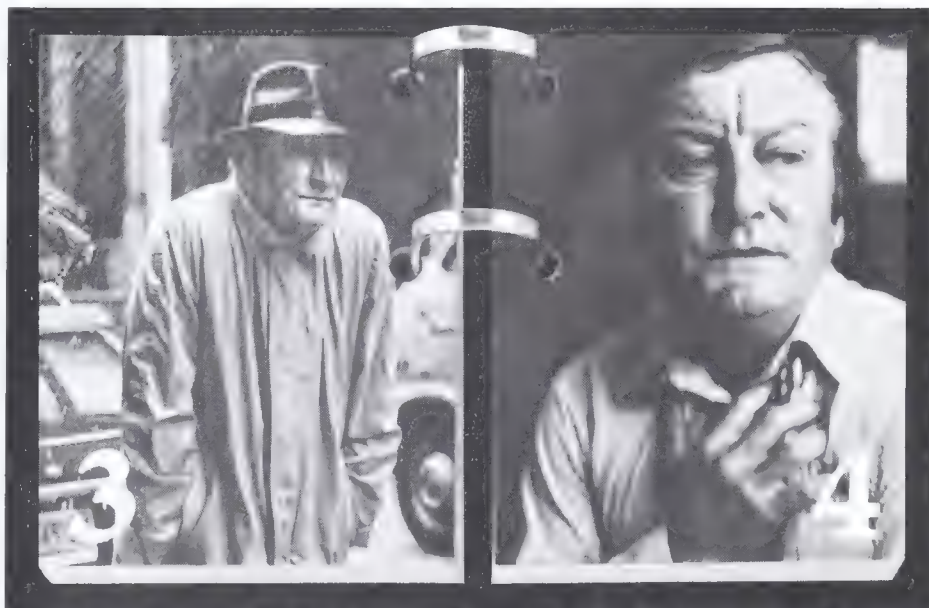
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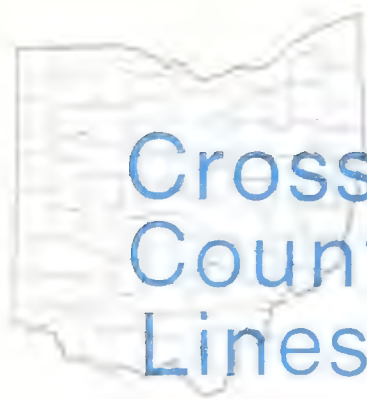


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Hyperalimentation in Inflammatory Bowel Disease

"Surgical" and "Nonsurgical" Roles

Robert L. Ruberg, M.D.
Ezra Steiger, M.D.

The intravenous hyperalimentation technique has been used in a variety of roles for patients with inflammatory bowel disease. These roles include three "surgical" functions (preoperative preparation, postoperative support, and adaptation after intestinal resection), as well as three "nonsurgical" functions (closure of gastrointestinal fistulas, supplementation in short bowel syndrome, and "primary" therapy). Indications for and results of each of these forms of therapy are described.

SINCE ITS INTRODUCTION in the late 1960s, the intravenous hyperalimentation (IVH) technique has been used in a wide variety of clinical settings.¹⁻³ The technique allows for total nutrition to be delivered continuously into a large-bore central vein, thus avoiding the use of the gastrointestinal tract for necessary periods of time.⁴ One of the earliest of applications was in patients with inflammatory bowel disease.⁵ More recent clinical and laboratory data have provided substantiation for the use of hyperalimentation in this disease process. We will review the various roles of intravenous hyperalimentation in patients with inflammatory bowel disease and, where possible, outline the experimental or clinical studies which support these applications.

The roles of hyperalimentation may be roughly divided into "surgical" and "nonsurgical" uses. These may be subdivided as follows:

Surgical:

1. Preoperative preparation
2. Postoperative support
3. Maintenance during adaptation after intestinal resection

Nonsurgical:

4. Closure of fistulas
5. Supplementation in cases of short bowel syndrome
6. "Primary" therapy

Preoperative Preparation

The demonstration that intravenous hyperalimentation could produce positive nitrogen balance, weight gain, and wound healing made this technique particularly useful in the preoperative preparation of debilitated patients. Many patients undergoing surgery for inflammatory bowel disease present to the hospital in a state of chronic malnutrition. Despite a relative state of poor nutrition produced by gastrointestinal tract malfunction, many patients require surgery because of an acute exacerbation of their disease process, often accompanied by fever, rapid weight loss, diarrhea, and bleeding. All of these factors contribute to an increase in operative risk. If time permits, the inflammatory-bowel-disease patient in this condition can benefit from a period of preoperative, intravenous hyperalimentation. In this interval, weight loss can be halted or reversed, serum protein levels increased, and nitrogen balance improved.⁶

Postoperative Support

Patients requiring emergency or urgent surgery for inflammatory bowel disease often will benefit from postoperative nutritional support in the form of hyperalimentation. They frequently present with an acute exacerbation of a chronic disease process, making their chances of postoperative complications rather high. The use of postoperative nutrition has appeared to decrease the incidence

of wound dehiscence, anastomotic leaks, and other complications of surgery. Recent laboratory experimentation appears to support this impression. Using a rat hyperalimentation model, it has been shown that by providing sufficient calories and amino acids intravenously in the postoperative period, one could demonstrate weight gain, serum albumin regeneration, improved liver cell morphology, and enhanced wound healing in protein-depleted animals. The strength of an experimental colon anastomosis was significantly higher in animals on a hyperalimentation-type regimen, when compared with those receiving ordinary dextrose and water intravenously in the postoperative period.⁷ These laboratory data, combined with clinical observations, help to demonstrate the importance of IVH in postoperative management of the inflammatory-bowel-disease patient.

Bowel Adaptation

One special area of IVH use is in patients who have undergone massive bowel resection. Hyperalimentation has been shown to play a critical role in the adaptation of the intestine after massive resection. An experimental study reported results after 90- to 95-percent bowel resections in puppies. One group of the animals was fed a standard oral diet, while a second group was given an additional complete diet intravenously for one month after surgery. The animals fed both enterally and parenterally achieved near-normal weight gain after the feeding was stopped, as contrasted with the orally fed animals, who grew to only one-half normal size. In addition, when examined one year later, the intestine of the animals fed both enterally and parenterally showed villous hypertrophy and increased cellularity, while that of the orally fed animals did not.⁸

These experiments suggest that the immediate supportive use of IVH after massive bowel resection aids in intestinal adaptation to the short bowel state. Clinically, the intentional creation of the short bowel state, of course, is avoided wherever possible, but in those rare events where this does occur, the patient apparently can benefit significantly from IVH in the early postoperative period.

Closure of Fistulas

One of the earliest "nonsurgical" uses of the IVH technique was in patients with gastrointestinal tract fistulas. In the past, mortality rates in patients with gastrointestinal fistulas were reported as high as 40 to 45 percent. The patient with inflammatory bowel disease who develops an enterocutaneous fistula (either postoperatively or spontaneously) often is malnourished, with such additional problems as skin breakdown, electrolyte imbalance, and hypoproteinemia. Recent studies have shown that improvements in nutritional state can lead to higher survival rates in patients with fistulas.⁹ The physician is faced with the challenge of providing adequate nutrition to patients who already have significant gastrointestinal tract dysfunction—inflammatory bowel disease—plus a fistula. We feel that the ideal solution to this problem is

to bypass the gastrointestinal tract entirely and deliver total nutrition through the intravenous route.

Putting the gastrointestinal tract at rest and using IVH in fistula patients has resulted in a decrease in fistula drainage, an increase in spontaneous fistula closure rate, and a reduced mortality rate in these patients.¹⁰

A study in dogs compared fistula-volume output using different diets and fistulas experimentally placed at different levels.¹¹ In both proximal and distal gastrointestinal tract fistulas, IVH resulted in a significant reduction of fistula output, when compared with both a "normal" and an elemental diet. The elemental diet showed a decrease in output in distal intestinal fistulas only; the reduction in volume was not nearly as great as that achieved with IVH.

What is the clinical importance of the reduction in fistula output? A recent review of patient data in a large series has shown that spontaneous (nonoperative) healing of fistulas occurred more than 70 percent of the time when patients were treated with hyperalimentation and bowel rest. Those patients whose fistulas did not close spontaneously appeared to tolerate surgical closure very well because of their improved nutritional state. The overall mortality rate in the 62 patients in this study was reduced to less than 7 percent.¹⁰ These data demonstrate dramatically the vital role that IVH can play in patients with inflammatory bowel disease who develop fistulas.

Supplementation in Short Bowel Syndrome

A second "nonsurgical" role of IVH is in the patient with established short bowel syndrome. Most often, this clinical picture appears in patients after an abdominal catastrophe such as bowel infarction but, occasionally, the syndrome is encountered in inflammatory-bowel-disease patients who have had multiple resections or bypass procedures. A combination of enteral feeding techniques often suffices to maintain their adequate nutrition. However, the functional length of the small bowel in these patients occasionally is insufficient to maintain adequate nutrition. In such cases, hyperalimentation can be used in either of two ways.

The first method is the use of the "refueling" technique. The patient is admitted to the hospital periodically for an intensive period of intravenous nutritional therapy to supplement inadequate oral diets. The frequency of

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hospital admissions is proportional to the severity of the patient's disease.

The second technique is the use of home hyperalimentation. Several recent publications have documented the feasibility of this technique in selected cases. The use of home hyperalimentation in the nutritional cripple avoids the marked fluctuations in weight and nutritional state encountered with the "refueling" method.

Whatever method is used, the patient with inflammatory bowel disease, who is a nutritional cripple from surgery or his own disease, can maintain a relatively normal existence through the supplemental use of parental hyperalimentation techniques.

Primary Therapy

The first use of IVH in inflammatory-bowel-disease patients was reported in 1969.⁵ Most of the patients in that series had pre- and/or postoperative use of IVH. However, an interesting phenomenon was observed in this original series of 13 patients, and eventually led to the use of IVH as primary therapy for inflammatory bowel disease. We noted that patients receiving IVH as preoperative preparation for a planned bowel resection showed so much improvement that their surgery was cancelled. As these patients usually were markedly debilitated, surgery was felt to be quite risky without some form of preliminary nutritional rehabilitation. The unexpected success in improving the bowel disease in these patients led to the concept of IVH as primary therapy for inflammatory bowel disease.

More and more physicians now have found that a course of bowel rest and total intravenous nutrition can result in significant improvement in the clinical and radiographic picture of inflammatory bowel disease, to the extent that surgery frequently can be avoided.¹² We feel this is an appropriate form of therapy in the following cases:

1. The debilitated patient for whom surgery is a clear risk
2. The patient with diffuse disease for whom a logical operation is difficult to plan
3. The patient who has already had a major bowel resection and in whom further surgery might produce the short gut syndrome.

As more data concerning the safety and effectiveness of this therapy accumulates, the use of hyperalimentation as primary therapy for all patients with significant inflammatory bowel disease, particularly those not re-

sponsive to more standard "medical" therapy, may be justified ultimately.

This final role of hyperalimentation is probably the most controversial role at present, but it has the potential of the most important function of IVH in the management of patients with inflammatory bowel disease.

Summary

Intravenous hyperalimentation can be used in a variety of roles for patients with inflammatory bowel disease. "Surgical" uses include preoperative preparation, postoperative support, and maintenance during adaptation after intestinal resection. "Nonsurgical" uses include fistula closure, supplementation in short bowel syndrome, and "primary" therapy. Thus, hyperalimentation is an invaluable adjunct in the management of patients with inflammatory bowel disease.

References

1. Dudrick SJ, Wilmore DW, Vars HM, et al: Long-term total parenteral nutrition with growth, development and positive nitrogen balance. *Surgery* 64:134-142, 1968.
2. Filler RM, Eraklis AJ, Rubin VG, et al: Long-term total parenteral nutrition in infants. *New Engl J Med* 281:589-594, 1969.
3. Dudrick SJ, Rhoads JE: New horizons for intravenous feeding. *JAMA* 215:939-949, 1971.
4. Dudrick SJ, Ruberg RL: Principles and practice of parenteral nutrition. *Gastroenterology* 61:901-910, 1971.
5. Steiger E, Wilmore DW, Dudrick SJ, et al: Total intravenous nutrition in the management of inflammatory disease of the intestinal tract. *Fed Proc* 28:808, 1969.
6. Dudrick SJ, Steiger E, Long JM, et al: Role of parenteral hyperalimentation in management of multiple catastrophic complications. *Surg Clin North AM* 50:1031-1038, 1970.
7. Steiger E, Daly JM, Allen TR, et al: Post-operative intravenous nutrition: Effects on body weight, protein regeneration, wound healing and liver morphology. *Surgery* 73:686-691, 1973.
8. Wilmore DW, Dudrick SJ, Daly JM, et al: The role of nutrition in the adaptation of the small intestine after massive resection. *Surg Gynecol Obstet* 132:673-680, 1971.
9. Sheldon GF, Gardiner BN, Way LE, et al: Management of gastrointestinal fistulas. *Surg Gynecol Obstet* 133:385-389, 1971.
10. MacFadyen BV Jr, Dudrick SJ, Ruberg RL: Management of gastrointestinal fistulas with parenteral hyperalimentation. *Surgery* 74:100-105, 1973.
11. Wolfe BM, Keltner RM, Willman VL: Intestinal fistula output in regular, elemental and intravenous alimentation. *Am J Surg* 124:803-806, 1972.
12. Fischer JE, Foster GS, Abel RM, et al: Hyperalimentation as primary therapy for inflammatory bowel disease. *Am J Surg* 125:165-175, 1973.

Acute Solitary Diverticulitis of the Ascending Colon

Richard E. Welling, M.D.

Acute solitary diverticulitis of the ascending colon occasionally is encountered during laparotomy for acute appendicitis. This is a localized inflammatory process in the ascending colon, resulting from an obstruction of the mouth of a solitary diverticulum by a fecalith. Differentiation from carcinoma may be difficult. Awareness of this clinical syndrome is essential for adequate surgical diagnosis and treatment.

UNEXPECTED PATHOLOGY occasionally is encountered during laparotomy for acute appendicitis. These lesions are discussed frequently in the differential diagnosis of acute appendicitis.¹ Acute solitary diverticulitis of the ascending colon is rare. The purpose of this report is to call the surgeon's attention to this clinical entity, and to discuss the surgical pathology, etiology, and treatment.

Clinical History

The presenting complaint is pain in the right iliac fossa of less than 24 hours' duration. The pain is non-migratory in nature, and vomiting frequently is absent. The remaining history is indistinguishable from appendicitis.

On examination, there is a low-grade fever with localized tenderness in the right midabdomen. The point of maximum tenderness is superior to McBurney's point; rectal tenderness is absent.

Leukocytosis is present but anemia, frequently associated with carcinoma of the cecum, is absent. A solitary diverticulum can be seen occasionally on a preoperative barium enema examination.

A correct preoperative diagnosis is rare. The differential diagnosis involves the following:

- (A) Acute appendicitis
- (B) Right renal stone
- (C) In the female (right side), ectopic pregnancy
Ovarian tumor (with or without rupture)
Twisted ovary
- (D) Right lower-lobe pulmonary infection
- (E) Meckel's diverticulum

However, past history of an appendectomy should alert one to the possibility of this condition.

Surgical Pathology

The appendix is normal at laparotomy. A portion of the ascending colon is inflamed and edematous with induration extending into the right mesocolon. The colon immediately proximal and distal to the lesion is normal. A small ulcer can be palpated through the anterior cecal wall and can be seen when the bowel is opened (Fig.1); a fecalith is found in the base of the ulcer in about 50 percent of the patients (Fig. 2).²

On cross section, the ulcer extends through the entire thickness of the bowel wall with a surrounding border

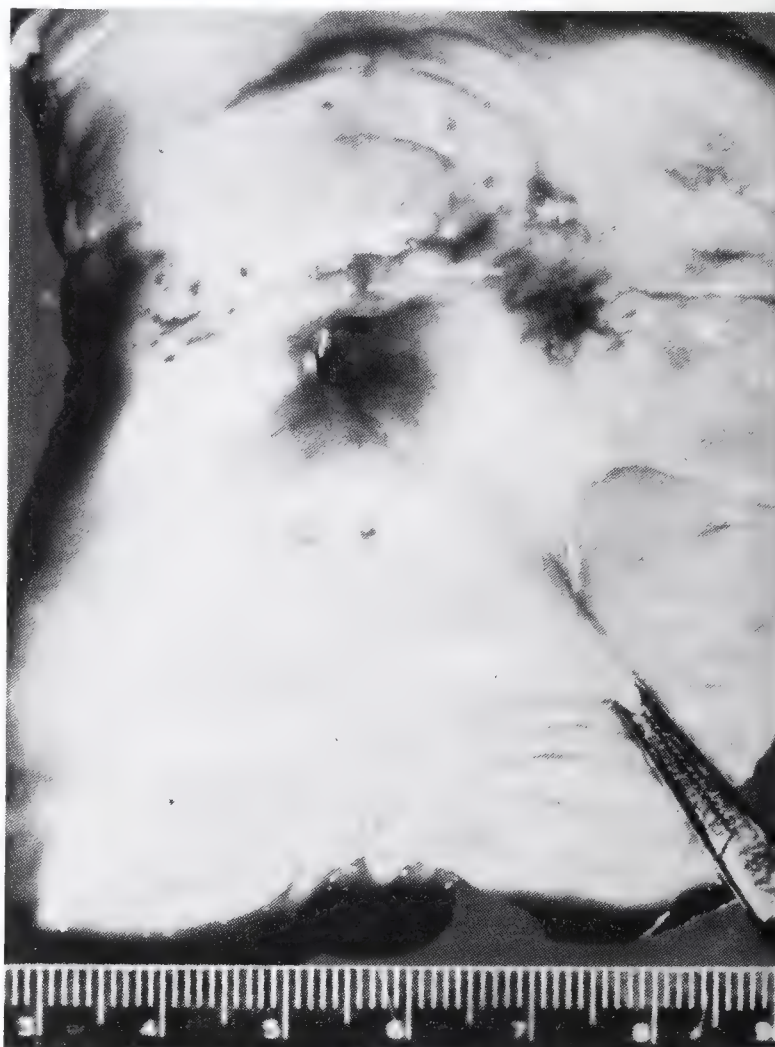


FIG. 1. Ulcer palpable through anterior cecal wall.

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Submitted December 16, 1975.

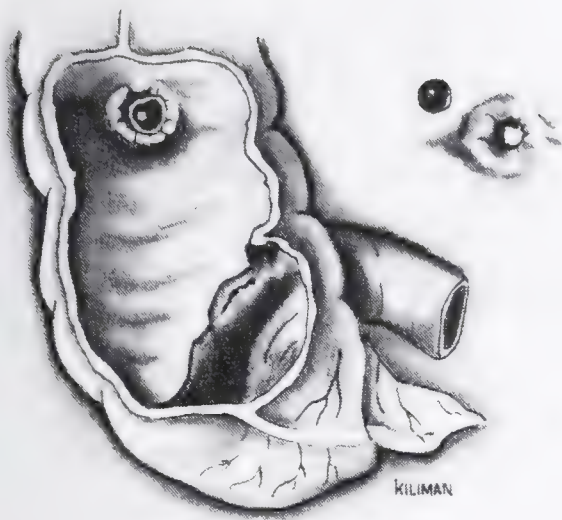


FIG. 2. Diagram of fecalith present in base of ulcer.

of inflammation and edema (Fig. 3). The mucosa is destroyed with extension through the bowel wall into the subserosal fat. The base of the ulcer is lined with inflammatory cells and necrotic exudate (Fig. 4).

Discussion

Acute solitary diverticulitis of the colon is a well-recognized clinical entity.^{3,4} It was first reported by Barron in 1928.⁵ A congenital basis has been postulated for the etiology of the diverticulum.⁶ Subsequent obstruction of the mouth of the diverticulum by a fecalith results in acute inflammation and ulcer formation. This acute inflammatory process is the basis of the clinical syndrome. The majority of solitary diverticula occur in the cecum

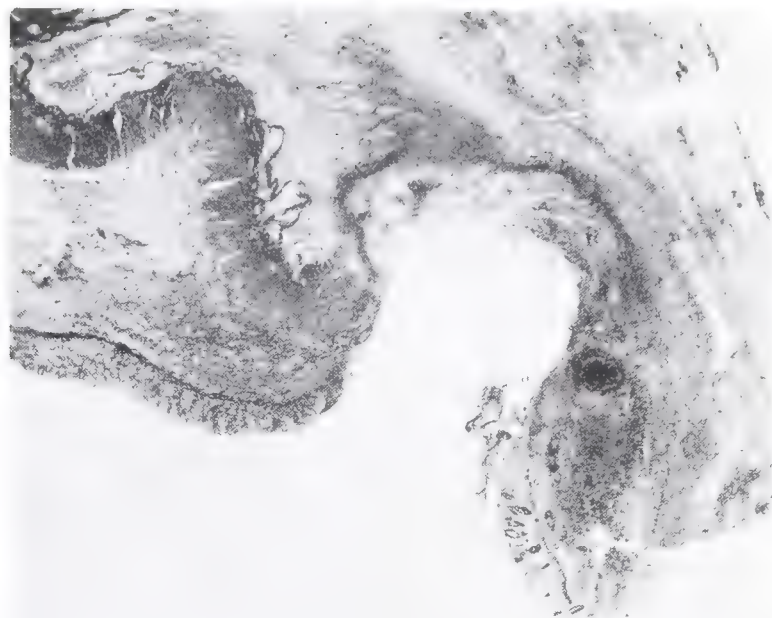


FIG. 4. Inflammatory cells and necrotic exudate lining base of ulcer.

and ascending colon; however, they have been reported throughout the colon.⁷ In four of the ten patients in Williams' series,⁶ the upper sigmoid was the site of occurrence.

Differentiating this lesion from acute appendicitis preoperatively is very difficult. The initial impression at laparotomy, after palpating such an ulcerated mass in the ascending colon, is that of carcinoma. One can only arrive at the correct diagnosis by awareness of this clinical condition. The acute inflammation can resolve spontaneously with obliteration of the diverticulum; appendectomy was the only form of treatment in some instances.⁸ However, if the diagnosis is obvious at the time of laparotomy or if the lesion has perforated into the right mesocolon, local resection to include the area of inflammation should be performed. In some patients, because of the proximity of the ileocecal valve, limited resection of the cecum with an ileal-ascending colostomy is necessary.

References

1. Cope Z: *The Early Diagnosis of Acute Abdomen* (ed 9), London, Oxford University Press, 1946, p 47.
2. Lauridsen J, Ross FP: Acute diverticulitis of the cecum. A report of four cases and a review of one hundred fifty-three surgical cases. *Arch Surg* 64:320-330, 1952.
3. Massie JR Jr, Michaux RA, Natvig RA: Benign solitary ulcers of the colon. *Am Surg* 29:557-562, 1963.
4. Smithwick W III, Anderson RP, Ballinger WF II: Non-specific ulcer of the colon. *Arch Surg* 97:133-138, 1968.
5. Barron ME: Simple, nonspecific ulcer of the colon. *Arch Surg* 17:355-407, 1928.
6. Williams KL: Acute solitary ulcers and acute diverticulitis of the caecum and ascending colon. *Brit J Surg* 47:351-358, 1959.
7. Barlow D: Simple ulcers of the caecum, colon, and rectum. *Brit J Surg* 28:575-581, 1940.
8. Lipton S, Reisman ED: Simple ulcer of the cecum. *Ann Surg* 134:279-282, 1951.

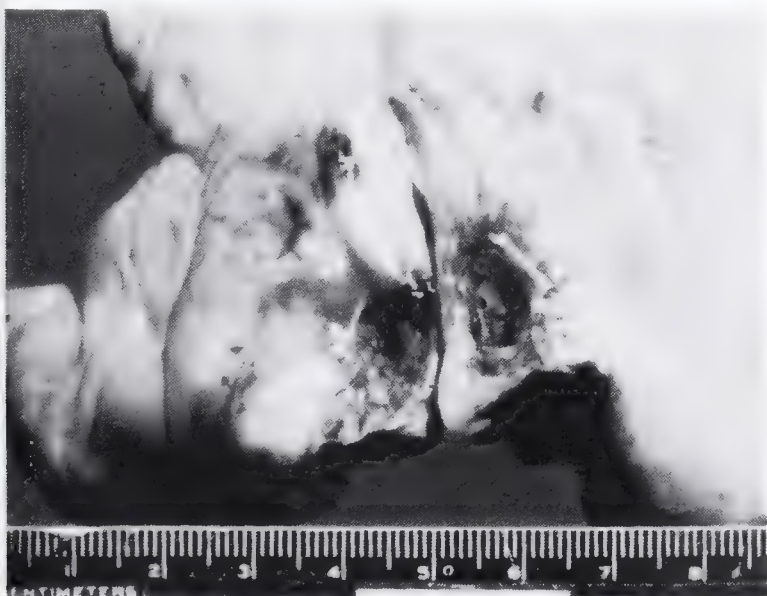


FIG. 3. Border of inflammation and edema surrounding ulcer.

Evaluation of Bacitracin* Ointment in the Treatment of Impetigo

Katalin I. Koranyi, M.D.
Dennis L. Burech, M.D.
Ralph E. Haynes, M.D.

The effectiveness of bacitracin ointment and erythromycin estolate oral suspension therapy was compared in 30 children with impetigo. Treatment with the systemic antibiotic was superior to the topical therapy in healing and limiting the spread of the lesions.

IMPETIGO IS A VERY COMMON superficial skin infection in children. The lesions begin as vesicles, progress to pustules, and then become exudative and crusted. Bullous impetigo in the neonate usually is caused by *Staphylococcus aureus* (*Sta aureus*), whereas impetigo in other children usually is caused by *Streptococcus pyogenes* Group A (Group A strep). In the case of mixed infections, it appears that *Sta aureus* is a secondary invader.¹

The optimum method of therapy for impetigo has not been established. Acute glomerulonephritis (AGN) may follow impetigo caused by nephritogenic strains of streptococci. It has been suggested, therefore, that systemic antibiotics should be used to prevent AGN. The role of systemic antibiotics in the prevention of AGN has not been clearly established, but topical antibiotics usually control the skin infection.²

The present study was undertaken to compare the efficacy of topical and systemic antibiotics in the treatment of impetigo.

Materials and Methods

Thirty children with impetigo, seen in the Outpatient Department of Columbus Children's Hospital from September through November 1974, were enrolled in the study. Patients who had had antibiotic therapy within the preceding two weeks were excluded. Physical examinations were made of all children, and the severity of impetigo was determined by estimating the number of lesions. Patients with six or fewer lesions were considered

to be mild cases, those with 7 to 20 lesions classed as moderate, and those with 20 or more lesions or confluent areas of skin infection were considered severe. Cultures of the impetiginous lesions in all patients were obtained during the initial visit. The lesion to be cultured was swabbed with 70-percent isopropyl alcohol, the crust was removed, and the moist area underneath was cultured with a sterile swab. This material then was inoculated onto 5-percent sheep blood agar plate and incubated 37 C for 24 hours. Group A Strep was identified by characteristic colonial morphology in association with beta hemolysis and sensitivity to bacitracin. *Sta aureus* was identified by colonial morphology and a positive coagulase reaction.

Fifteen children were treated with Bacitracin Ointment® (500 units per gm), four times a day, and were given a placebo suspension simulating erythromycin estolate every six hours. The other group of 15 children was treated with erythromycin estolate suspension, 250 mg every six hours, and given a placebo ointment. Drug assignment was based on a random distribution table, without the knowledge of the authors. All patients were evaluated every other day; they were treated for six days.

Results

Thirty patients, ages two months to 15 years, were studied. There were 14 males and 16 females. All the children were observed a minimum of six days. The extension of the impetiginous lesions was comparable in those treated with Bacitracin Ointment and erythromycin.

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Submitted December 10, 1975.

*Bacitracin—A polypeptide produced by the growth of a gram-positive spore-forming organism belonging to the licheniformis group of *Bacillus subtilis* (Dorland's *Medical Dictionary*).

The lesions were mild in 60 percent of the patients, moderate in 37 percent, and severe in 3 percent. Bacteria isolated from the initial cultures yielded Group A streptococcus in 6.7 percent of the patients, *Sta aureus* in 46.7 percent, both organisms in 26.7 percent, and no organism was recovered in 19.9 percent (Table 1).

Response to therapy was excellent (complete or near-complete healing of all the lesions at the end of six-day therapy and without developing new lesions) in ten patients (66.67 percent) treated with erythromycin and in five patients (33.33 percent) treated with Bacitracin Ointment. The response was considered satisfactory if new lesions developed early in the treatment, and all the lesions were healing well by the sixth day. In five patients (33.33 percent) treated with erythromycin and in eight (53.33 percent) treated with Bacitracin Ointment, the response was satisfactory. Two patients treated with bacitracin were considered therapeutic failures (13.33 percent). Their lesions showed only slight improvement by the sixth day, and new lesions continued to develop through the ninth day. They were treated with intramuscular injections of penicillin G benzathine, and the lesions healed promptly. The lesions of one child healed well on erythromycin therapy, but the patient developed regional lymphadenitis three days after the antibiotic was discontinued. He was treated then with penicillin G benzathine intramuscularly (Table 2). No serious side effects were observed in either group, although two children had mild abdominal cramps while taking erythromycin.

Comments

Impetigo is caused by Group A strep, *Sta aureus*, or by both organisms. Hughes and Wan isolated Group A strep from the skin lesions in 17.7 percent, staphylococcus in 22.5 percent, and both organisms in 29 percent of their 62 patients.³ Of 102 children studied by Ruby and Nelson, Group A strep was recovered from 33 (32.35 percent) and the combination of both organisms from 57 (55.88 percent).⁴ In the study of Hall, et al, skin cultures yielded Group A strep from 75 percent of the 113 children.⁵ Esterly and Markowitz found that Group A strep caused impetigo in 27.2 percent of their patients, while *Sta aureus* was isolated from 37.3 percent and both organisms from 35.3 percent.⁶ In the present study, cultures of the skin lesions yielded Group A strep in only 6.7 percent of the 30 children, while *Sta aureus* was isolated almost seven times more frequently (46.7 percent). Both organisms were found in 26.7 percent of the patients. The reason for the differences in the studies is not clear, however, such factors as age, geographic distribution, and duration of the lesions may be important. In the early vesicular or pustular stages of impetigo, pure cultures of Group A strep are frequent, and both organisms are more common during the crusting stage. Staphylococcus alone is isolated most often in the healing lesions.⁷

Many modes of therapy have been advocated for the treatment of impetigo, including the mechanical

TABLE 1. Organisms Recovered from Skin Lesions in Patients

Organism	No. of Patients	%
Group A strep	2	6.7
<i>Sta aureus</i>	14	46.7
Both organisms	8	26.7
No organisms	6	19.9
Total	30	100.0

removal of crusts and cleansing with soap, topical antibiotics, and systemic antibiotics. Cleansing and local application of an ointment containing bacitracin, neomycin, and polymixin B (Mycitracin®) proved to be an effective therapy for impetigo in 99 percent of the children studied by Hall, et al.⁵ According to Morley, the treatment of choice for impetigo is topical antibiotics, with systemic antibiotics reserved for those patients with fever and lymphadenopathy.⁸ Ruby and Nelson demonstrated that scrubbing vigorously with hexachlorophene did not influence the rate of healing of lesions.⁴ Daily bathing was equally effective and acceptable to most of the children. Their study also showed that ten days of oral penicillin therapy produced healing in 99 percent of the patients, while Bacitracin Ointment was effective in only 19 percent. Esterly and Markowitz compared the effectiveness of penicillin G benzathine and topical antibiotics (gentamicin sulfate, and a mixture of bacitracin zinc, neomycin sulfate, and polymyxin B sulfate) in 209 children with impetigo. Penicillin was superior to topical treatment, and gentamicin ointment was the least effective.⁶ Farah, et al obtained similar results with gentamicin and neomycin ointments.⁹ Derrick and Dillon reported the results of various treatment regimens in 1,182 patients with Group A strep impetigo.⁷ A cure rate of 97 to 98 percent was observed in those treated intramuscularly with penicillin G benzathine, or orally with erythromycin or phenoxymethyl penicillin. The lesions healed in only 9 percent of patients treated with hexachlorophene scrubs and in 39 percent with hexachlorophene and Bacitracin Ointment. Similar data were obtained by Hughes and Wan, who compared the effectiveness of oral erythromycin succinate and a topical antibiotic ointment (Neosporin®).³ The oral antibiotic was more effective than the topical therapy in healing the lesions and in eradicating the caustive organisms. At one-month follow-up after initiation of therapy, skin cultures were negative in 100 percent of the patients treated with erythromycin and in 93 percent of those treated topically. In our study, all 15 patients responded well to the oral administration of

TABLE 2. Results of Antibiotic Therapy

Antibiotic	Excellent	Satisfactory	Failure
Erythromycin	10 (66.7%)	5 (33.3%)	—0—
Bacitracin	5 (33.3%)	8 (53.3%)	2 (13.3%)

erythromycin. However, one patient developed lymphadenitis three days after therapy was discontinued. Six days of antibiotic therapy, therefore, may not be sufficient. Healing of lesions was slightly slower when patients were treated with Bacitracin Ointment. Two children showed no improvement and continued to develop new lesions while being treated with topical ointment.

It would seem logical to treat impetigo with penicillin parenterally, in those geographic areas where nephritogenic strains of Group A strep are frequent. However, evidence that penicillin treatment will reduce the incidence of post-streptococcal nephritis is lacking. Kaplan, et al reported 25 patients with acute glomerulonephritis, and 21 of them had a documented history of impetigo.¹⁰ Three of these patients had received adequate treatment with penicillin G benzathine intramuscularly, four weeks, three weeks, and 5 days, respectively, before the onset of nephritis. Similarly, in 303 cases of impetigo studied by Markowitz and Taranta, 14 developed hematuria, even though 5 of the 14 had received penicillin parenterally.¹¹ Of the 62 patients with impetigo reported by Hughes and Wan, one patient treated with topical antibiotic developed acute glomerulonephritis.³

Conclusion

Early treatment of impetigo with systemic antibiotics seems to be superior to the topical therapy in limiting the spread of the lesions. Until such time as there is definitive information about the role of systemic antibiotic therapy in the prevention of post-streptococcal nephritis in patients with impetigo, it would seem prudent

to recommend systemic therapy with penicillin for ten days.

Generic and Trade Names of Drugs

Bacitracin Topical Ointment (Eli Lilly)

Mycitracin Ointment (Upjohn)

Polymyxin B-Bacitracin-Neomycin—Neosporin (Burroughs Wellcome)

References

1. Anthony BF, Kaplan EL: Treatment of superficial skin infections in children. *GP* 36:123-127, 1967.
2. Weinstein L, LeFrock J: Does antimicrobial therapy of streptococcal pharyngitis or pyoderma alter the risk of glomerulonephritis? *J Infect Dis* 124:229-231, 1971.
3. Hughes WT, Wan RT: Impetigo contagiosa: Etiology, complications, and comparison of therapeutic effectiveness of erythromycin and antibiotic ointment *Am J Dis Child* 113:449-453, 1967.
4. Ruby RJ, Nelson JD: The influence of hexachlorophene scrubs on the response to placebo or penicillin therapy in impetigo. *Pediatrics* 52:854-859, 1973.
5. Hall WD, Blumberg RW, Moody MD: Studies in children with impetigo. Bacteriology, serology, and incidence of glomerulonephritis. *Am J Dis Child* 125:800-806, 1973.
6. Esterly NB, Markowitz M: The treatment of pyoderma in children *JAMA* 212:1667-1670, 1970.
7. Derrick CW Jr, Dillon HC Jr: Impetigo contagiosa. *Am Fam Physician* 4:75-81, 1971.
8. Morley N: The treatment of skin diseases in childhood. *Practitioner* 204:97-108, 1970.
9. Farah FS, Kurban AK, Malak JA, et al: The treatment of pyoderma with gentamicin. *Br J Dermatol* 79:85-88, 1967.
10. Kaplan, EL, Anthony BF, Chapman SS, et al: Epidemic acute glomerulonephritis associated with Type 49 streptococcal pyoderma. I. Clinical and laboratory findings. *Am J Med* 48:9-27, 1970.
11. Markowitz M, Taranta A: Managing streptococcal infections. *Drug Ther* 3:20-31, 1973.

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Maternal Health

Maternal Deaths Involving Lower Nephron Nephrosis

By the OSMA Committee on Maternal and Neonatal Health*

Editor's Note: The function of the OSMA Committee on Maternal and Neonatal Health is the basis for a very extensive contribution of the medical profession in Ohio to the preservation of life and health of mother and child, family, and society as a humanitarian contribution of the physician to his fellow man and his community. This is a true gift to our social order.—R.L.M

FOR THE PAST 15 YEARS, the Committee has been painfully perplexed by the complex facts involving maternal death precipitated by kidney failure, renal shutdown, uremia (more accurately defined as "lower nephron nephrosis"), or renal cortical necrosis. Reports have been published in this column under a similar title describing the pathologic processes preceding or contributing to the final event: transfusion reaction,¹ hemorrhage and sepsis,² and obstetric hemorrhage.³

Innumerable articles have appeared in the past relating explanations and research in an effort to clarify the clinical and pathologic problems associated with lower nephron nephrosis. The Schwartzman phenomenon and afibrinogenemia, described particularly by McCally and

Vasicka,⁴ engendered interest of Committee members and resulted in our second article on this subject.²

The Committee presents herein clinical data on three patients who died as a result of lower nephron nephrosis associated with sepsis and involving phlebitis, septic abortion, and peritonitis, respectively. The comments of a consultant known as a "nephrologist" are at the end of this report.

The first patient was an obese, high-risk multipara in the second decade of her life. She was admitted to the hospital at term, in active labor, with ruptured membranes. She also complained of a very painful breast; no notation was made on the examination form. She was febrile. Labor continued, and the patient was delivered of a large, living baby, by forceps and over an episiotomy. Antibiotic therapy was started at once and was continued. Several days later, pain in the breast subsided but a severe pain in the calf of the leg appeared accompanied by further elevation of temperature. The hemogram revealed moderate anemia but no relative leukocytosis; the urine carried 3+ albumin and was "loaded with leukocytes." Two days later, the diagnosis of a consultant was: "acute deep phlebitis, sinus tachycardia, and anxiety reaction." Anticoagulant therapy was initiated. The patient soon became nervous, agitated, dyspneic, and cyanotic. Chest examination revealed the lung fields were clear. That evening, her temperature "spiked," jaundice developed, and a downhill clinical course ensued. The patient died less than one week post-partum. An autopsy was permitted.

Cause of Death (Autopsy): Bilateral, renal cortical necrosis; disseminated fibrin thrombi of the lung, kidneys, adrenals, and esophagus; passive hyperemia of lungs; generalized Schwartzman reaction; obesity; generalized icterus.

Comment

The Committee studied the bizarre facts in this case, observing an overwhelming sepsis apparently initiated with mastitis, later complicated by phlebitis, and terminating in an endotoxic shock phenomenon, despite ther-

*A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal and Neonatal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the studies by the Committee, based on anonymous data submitted, are presented from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

apy. Members felt this was a nonpreventable maternal death in a high-risk patient.

This patient was a white, single, primigravida in her early 20s. Her past history is not known, but a week and a half before admission, an attempt was made to abort a first-trimester, uterine pregnancy. The professional qualifications of the abortionist(s) are not known. A week later, allegedly, a second attempt was made to terminate her pregnancy; abdominal pain followed promptly. She soon passed a fetus, became icteric with abdominal distention, and was admitted to the hospital the following morning. A dilation and curettage was performed. An antibiotic was administered, dosage unknown; oliguria developed; and the hemogram showed marked leukocytosis. Her fever persisted and the oliguria continued, with a diagnosis of "kidney failure." In kidney failure, she was transferred to a second hospital for immediate dialysis, the first of ten treatments. In spite of hypothermia and the other measures, the patient remained febrile and was critically ill. A colpotomy and uterine culture revealed no pus. In another two weeks, her condition seemed only slightly improved. A needle biopsy of the kidney revealed "acute tubular degeneration" with oliguria of several weeks' duration. A dilation and curettage and a subtotal hysterectomy were performed. A "ruptured fundus," cellulitis, and multiple pelvic abscesses with shreds of intrauterine "membranes" were found at the time of surgery. Vascular collapse followed, and the patient died the next day.

Cause of Death (Coroner's Autopsy): Lower nephron nephrosis, due to organizing general peritonitis with chronic suppurative endometritis and myometritis; perforated uterus.

Comment

Members of the Committee marveled at the length of time the patient survived after the innumerable insults to her physiologic economy. Obviously, responsibility rested with her initially seeking termination of the pregnancy from person(s) unknown.

The last patient in this series was a high-risk, teenage, white primigravida who began to have "problems" in the second trimester of pregnancy and continued on a steady "downhill clinical course" for the ensuing five months. There was a questionable history of chronic nephritis.

She registered with her physician in the middle of the first trimester with weight gain of two pounds per week. She was placed on a low salt diet and diuretics. Four months later, she had almost doubled the weight gain. She was hospitalized at that time; admitting diagnosis was "preeclampsia, moderate, possible chronic nephritis." Within four weeks, the blood uric acid was greatly elevated; the blood urea nitrogen (BUN) was slightly elevated; and an intravenous pyelogram revealed one functioning kidney, the opposite one anuric. Retrograde studies confirmed these reports. The following week, the patient was delivered of a living, term-size infant via cesarean section. In spite of antibiotic therapy, the patient's temperature "skyrocketed." Septicemia was considered but not proven; paralytic ileus developed. The BUN increased markedly as the temperature remained elevated; retrograde catheters still revealed one anuric kidney. Two weeks postoperative, peritoneal dialysis was commenced and, one day later, during convulsions and coma, the patient was transferred to a "center," where she died the following day, in spite of heroic therapy. An autopsy was permitted.

Cause of Death (Autopsy): "Renal shutdown"; acute and chronic pyelonephritis with proliferative, obliterative endarteritis, and arteriolitis with bilateral, multiple, recent, renal cortical infarcts; atypical membranous glomerulonephritis consistent with renal lesions of toxemia of pregnancy;⁵ paralytic ileus; septicemia (*Pseudomonas aeruginosa*).

Comment

The Committee studied this case with maximum interest. It seemed that the summary of events included renal infection, preeclampsia, septicemia, and peritonitis. The article referred to by the pathologist⁵ was somewhat

helpful. Members felt that the patient's medical history categorized her as a high-risk patient, and that pregnancy contributed to the worsening of a preexisting pathologic renal lesion.

Comment of Consultant

The following comment of a consultant, who is a nephrologist, was furnished at the request of The Committee:

"Increasing subspecialists in the field of renal disease have expanded the knowledge of kidney involvement in pregnancy. This is exemplified by the enormous increase in publications.⁶ The three mentioned cases are typical examples of involved, complicated problems requiring kidney specialists and dialysis.

"The first and second patients cited herein are examples of acute renal failure (which is synonymous with lower nephron nephrosis, shock kidney, or acute tubular nephrosis). The third patient presented clinical findings more typical of underlying renal disease that worsened with the pregnancy.

"The first patient's pathology was bilateral, renal cortical necrosis which is seen in approximately 25 percent of patients that have acute renal failure. It also was associated with a probable consumptive coagulopathy as there were petechiae in the skin and disseminated fibrin thrombi. These problems are not unexpected as pregnancy is associated with several factors that predispose to intravascular coagulation: (1) an increase in clotting factors, (2) the increased risk of gram-negative infections, (3) preeclampsia, and (4) abruptio placentae.⁷ Although no evidence of bacteremia was found, it is most likely that the patient died of overwhelming sepsis; that, in turn, led to cortical necrosis and disseminated intravascular coagulopathy.

"The death of the second patient was a result of a septic abortion, and there were resultant abscesses in the pelvic cavity. The highest cause of mortality in acute renal failure is infection, and both cases correlate these data.

"Both cases were treated with chloramphenicol and the latter also with surgical drainage. Chloramphenicol was a good choice of therapy for these patients although an aminoglycoside (gentamicin) for gram-negative bacteria also would have been appropriate.

"The third patient developed preeclampsia earlier than would be expected normally, as it occurred before the 30th week. Usually, preeclampsia occurs after the 32nd week,⁶ but the patient had albuminuria (4+) and edema at 7½ months. Pregnant females with underlying chronic glomerulonephrosis have an increased incidence of preeclampsia and fetal loss;⁸ the same is not known for chronic interstitial disease unless underlying, mild hypertension is noted.⁹ This patient then developed increasing azotemia and infections. The etiology of her bilateral cortical necrosis is not clear, but the acute, chronic pyelonephritis and membranous glomerulonephritis were contributing factors. This particular patient needed to be evaluated at a much earlier date, and possibly the preg-

nancy terminated, depending upon the serious degree of the underlying disease.”

References

1. OSMA Committee on Maternal Health: Maternal deaths involving lower nephron nephrosis. *Ohio State Med J* 57:660-661, 1961.

2. OSMA Committee on Maternal Health: Maternal deaths involving lower nephron nephrosis. *Ohio State Med J* 61:235-236, 1965.

3. OSMA Committee on Maternal Health: Maternal deaths involving lower nephron nephrosis. *Ohio State Med J* 71:846-847, 1975.

4. McCally M, Vasicka A: Septic abortion, the Schwartzman reaction and hypofibrinogenemia. *Obstet Gynecol* 20:359-364, 1962.

5. Pollak VE, Nettles JB: The kidney in toxemia of pregnancy: a clinical and pathological study based on renal biopsies. *Medicine* 39:469-526, 1960.

6. Ferris TF, Burrow GN (eds): *Medical Complications During Pregnancies*, Philadelphia, W B Saunders, 1975.

7. Bonnar J, McNicol GP, Douglas AS: Fibrinolytic-enzyme system in pregnancy. *Br Med J* 3:387, 1969.

8. Kincaid-Smith P, Fairley KF; Kidney disease in pregnancy. *Med J Aust* 2:1155, 1967.

9. Felding CF: Pregnancy following renal biopsies. *Clin Obstet Gynecol* 11:579, 1968.

Ohio Health News

John H. Ackerman, M.D., M.P.H.
Director of Health

Virus Serology

Serodiagnosis of viral and rickettsial diseases is demonstrated by a four-fold increase and, in some cases, a four-fold decrease in antibody titer. It is extremely important that two, well-chosen specimens be submitted for testing. The following are recommended techniques to be used when submitting specimens for encephalitis and other virus disease to the Ohio Department of Health Laboratory for serological diagnostic procedures.

Follow these instructions when submitting serum samples:

1. Draw only one acute and one convalescent specimen on a patient. The acute specimen must be drawn during the first week of illness. The convalescent serum should be collected two to three weeks after the onset of illness. **NOTE:** Convalescent in this case refers to that period of illness when the circulating antibody is at its maximum and is not necessarily related to the clinical condition of the patient.
2. Submit 2-5 ml of serum. Serum should be sent in a screw-cap or corked tube sealed with adhesive tape. Label each tube with the patient's name and the date the specimen was drawn. Serum may be sent by mail without refrigeration.
3. Submit a brief case history which includes date of onset of illness, description of the symptoms, course of treatment, tentative diagnosis, and specific tests desired. **NOTE:** Specimens received without this basic information will not be processed.

4. The Virus Laboratory offers a large number of serological tests. These tests are time-consuming and the reagents are expensive and often difficult to obtain. For this reason, we ask that no more than eight (8) specific tests be requested on a patient. Unless specific tests are indicated, the specimens will be held until this information is received.

Acute and convalescent sera must be run in parallel to demonstrate a four-fold increase or decrease in antibody titer. In most cases, the acute serum will be held until the convalescent specimen has been received.

The Ohio Department of Health Virus Laboratory does not offer tests for the following diseases or agents:

Hepatitis	Molluscum Contagiosum
EB Virus	Vesicular Stomatitis
Dengue	Tric Agents (Trachoma)
Erythema Infectiosum	Coronaviruses
(Fifth Disease)	Hemorrhagic Diseases
Exanthem Subitum	
(Roseola)	

Serum samples for some of the agents or syndromes listed above may be submitted through the Ohio Department of Health Laboratory for testing by the Center for Disease Control in Atlanta, Georgia. If a physician has questions regarding test procedures or wishes to submit a specimen for testing by CDC, please contact the Virus Laboratory for additional information (Telephone: 614-466-2280).

For a complete protocol for submission of specimens for virus isolation and serology write to Ohio Department of Health, Division of Public Health Laboratories, P.O. Box 2568, 1571 Perry Street, Columbus, Ohio 43216.

Accreditation Standards for CME Activities

The main objective of continuing medical education (CME) is the improvement of the health and well-being of the individual patient and of the public in general. This objective can be accomplished by (1) changing the attitudes of physicians, (2) correcting outdated knowledge, (3) introducing new knowledge, (4) mastering specific skills and techniques, and (5) improving the performance of physicians.

In order for each CME course offered in Ohio to contribute to the main objective of CME, standards have been developed for the accreditation of hospital, institutional, and organizational CME activities. If sponsoring organizations follow these standards, their CME courses should succeed in improving the health and well-being of the individual patient and of the public in general.

Director of Medical Education

The governing body, medical staff, and administration of the sponsoring institution should demonstrate support of CME. In addition, CME should be administered by a responsible person having the respect and backing of the medical staff and hospital administration.

Many hospitals have found it necessary to employ a physician as director of medical education because the burdens of this position can become too great to be carried by a volunteer member of the medical staff.

The director of medical education has numerous responsibilities: (1) determine the specific needs of the medical staff, (2) provide clear statements of the objectives of specific educational activities, (3) plan activities well in advance, (4) encourage involvement of all members of the medical staff, (5) insure that study areas and audiovisual and self-instructional aids are available, (6) publicize the CME effort to both the medical staff and the public, (7) supervise enrollment records, (8) coordinate educational activities for physicians with programs for allied medical personnel, (9) plan for evaluation of the program, and (10) encourage the provision of adequate library facilities and services.

County Medical Society

The county medical society can coordinate educational activities with other CME programs in the community and can develop strong working relationships with CME departments of nearby medical schools.

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Financial Support

Financial support of CME must be provided. Sole dependence upon tuition fees will restrict the quality, breadth, and depth of the educational program. Monetary support for CME could come from medical staff dues, hospital general funds, voluntary health agencies, federal funds, existing charitable foundations, and new hospital research and educational foundations.

Instructors and Format

The teaching staff may consist of physician members of the hospital medical staff. Frequently, it is desirable to enlist teachers from other hospitals and medical schools, although the main body of teaching should come from within the region. Those community hospitals with intern and residency programs should have a nucleus for a faculty that can be expanded to meet the demands of a solid CME program. In order that each community hospital may obtain necessary academic support for its program of continuing education, it is suggested that cooperation with medical schools or larger hospitals be established.

Newer knowledge of the basic mechanism of disease and treatment should be an integral part of the curricu-

lum along with more practical information. The curriculum should be coordinated with other hospitals and/or medical schools to avoid duplication and encourage adequate coverage.

Although there is need for the lecture format, educational methods requiring active participation should be encouraged. These methods include live clinics and bedside rounds, seminars, open question periods, laboratory work, and the study of patients under supervision.

Evaluation

Each educational activity of the entire continuing education program of an institution needs to be evaluated in terms of impact on the quality of patient care through review procedures similar to those followed in assessing needs. It should be noted that without an initial statement of specific objectives for each activity, it is difficult, if not impossible, to ascertain whether such objectives have been fulfilled.

Each physician's reward for participation in CME should be his improved ability to care for his patients and the stimulation of his own spirit of intellectual adventure. CME hours may, of course, be applied to the AMA and OSMA Physician's Recognition Awards.

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JULY 1976
Volume 72, Number 7

THE OHIO Medical Journal

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REPORT ON THE 1976
OSMA ANNUAL MEETING, PAGE 398

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Medical Hotline

Ohio's John H. Budd, M.D. New AMA President-Elect

John H. Budd, M.D., Cleveland, is the new President-Elect of the American Medical Association. He was elected July 1, 1976, at the 125th Annual Convention of the AMA held in Dallas, Texas. The 256 members of the AMA House of Delegates cast ballots in the contested race.

Dr. Budd has been extraordinarily involved in both the active, clinical practice of medicine and the socio-economic problems of the profession since his days as a medical student. The President-Elect, who maintains a solo family practice in Cleveland, had served on the AMA Board of Trustees for six years prior to this most recent victory. His other accomplishments and his stand on issues facing the profession are the subject of the article "A Profile for Progress: John H. Budd, M.D.," which appears in *The Journal*, Volume 72, Number 5 (May 1976).

All Ohio salutes Dr. Budd in his desire to advance the health care profession in the United States through his efforts as President-Elect and then President of the AMA. He will be installed as President of the AMA at the Annual Convention to be held in San Francisco in June of 1977.



Special Session Called For OSMA House of Delegates

A special session of the OSMA House of Delegates has been called for Sunday, August 1, 1976, at the Sheraton-Columbus Motor Hotel, 50 N. Third Street. The meeting will begin at 10 AM with registration starting at 9:30 AM in the promenade area of the second floor.

OSMA President George N. Bates, M.D., called the session for two purposes: (1) to report the recommendations of the OSMA Task Force on Professional Liability and the OSMA Council to form a physician-owned, medical, professional liability insurance company, and (2) to report to the House regarding countersuit activities.

There will be no other business before the House.

The special session of the House of Delegates is open to all OSMA members in good standing.

Federal Legislation Introduced On M.D. Flu Immunization Liability

There has been much concern in Ohio and around the nation about physician liability when participating in the mass influenza immunization program which the State of Ohio will begin shortly. H.R. 14569 (Carter-Kentucky) has been introduced in the U.S. House of Representatives to combat the liability problem. The OSMA supports this bill in principle.

The bill reads as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled, That section 311 (a) of the Public Health Service Act is amended by adding at the end the following: "The United States, through the Secretary, shall indemnify and hold harmless physicians and other health care personnel and health care facilities who provide, without charge except for necessary expenses, professional services in connection with the influenza immunization program authorized by Public Law 94-266 for any civil liability for damages (including the amount of any judgment or settlement and costs and expenses arising out of any claim or suit) for injury or death which results from the administering of, or supervision or responsibility for the administration of, influenza vaccine under such program and which is not the result of gross negligence."

On June 25, 1976, OSMA President George N. Bates, M.D., communicated with all OSMA Councilors and all county medical society presidents, secretaries, and executive secretaries concerning H.R. 14569. He stated in part: "I urge personal contact at once with your Congressmen, Senator Taft and Senator Glenn to solicit their active support of legislation to protect physicians, other health care personnel and facilities from subsequent malpractice action involving the forthcoming mass influenza immunization program."

Informally Trained Physician's Assistants May Take Examination

Informally trained Physician's Assistants will be eligible to sit for the Examination of the National Commission on Certification of Physician's Assistants (NCCPA) if they meet certain criteria. The criteria as listed in the NCCPA brochure are (1) high school diploma or equivalency certificate, (2) four years full-time medical clinical experience in primary care as a physician's assistant or nurse practitioner since January 1, 1972 (This experience must have been acquired within the U.S. or in the uniformed services of the U.S.), and (3) work experience meeting specified criteria as verified and evaluated by the NCCPA.

The deadline for receipt of completed applications for this certifying examination is August 16, 1976. Applications may be obtained from the NCCPA, 3384 Peachtree Road, N.E., Suite 560, Atlanta, Georgia 30326. Telephone: 404/261-1261. The examination is tentatively scheduled for November 19, 1976.

OSMA Auxiliary Design Selected As New AMA Auxiliary Seal

The design of Ohio State Medical Association Auxiliary member Gloria Naji (Mrs. Abdul F. Naji), Gates Mills, has been selected as the new AMA Auxiliary seal. Ohio's entry had been among six finalists chosen from designs submitted by all state medical association auxiliaries. The AMA Auxiliary delegates voted on the new seal at their national convention held recently in Dallas.

Mrs. Naji said of her design: "The laurel wreath seemed to me appropriate to use with our Aesculapian staff in that it also has a Graeco-Roman origin and was used as a mark of distinction for certain officers and later to indicate academic honors and achievement."

OSMA members are proud of their Auxiliary and its achievements. Congratulations.



6th Institute on Sports Medicine

The Sixth Postgraduate Institute on Sports Medicine, scheduled for August 4-6 at The Ohio State University's Columbus campus, will highlight screening of athletes for various sports, medical-legal aspects of the play-or-no-play decision, orthopedic considerations, the physician-trainer-coach relationship, and rotating seminars on various field procedures. Copies of the program and registration form have been mailed to all Ohio physicians, scholastic coaches, and trainers by the OSU Center for Continuing Medical Education. Additional copies are available from the Joint Advisory Committee on Sports Medicine, OSMA, 600 S. High Street, Columbus 43215. Physicians may obtain 14½ hours of Category 1 CME credit for attending the entire institute.

County President Praises OSMA

We have a superb executive staff in Columbus represented by Hart Page, Dave Rader and the others. They are constantly on the alert and are well informed. Like you, they work evenings and weekends, frequently putting in 80 hours a week. They need your cooperation.

William E. Sovik, M.D.
President, Mahoning County
Medical Society

(Reprinted from the *Bulletin of the Mahoning County Medical Society*, Volume XLVI, Number 5.)

ISO Retracts Rate Filing

OSMA was informed on July 2, 1976, that the Insurance Services Offices (ISO) has retracted its filing requesting a 145 percent malpractice premium rate increase.



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OSMA NEW MEMBERS

The Ohio State Medical Association welcomes the following physicians who joined the society during the month of May 1976. The list indicates the county and city in which each new member is practicing or taking postgraduate work. The support of these physicians for their state organization is appreciated.

CHAMPAIGN (Urbana)
Sher S. Guleria

CUYAHOGA (Cleveland)
Chi Chih Tsai
Phillip I. Whong

FRANKLIN
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Stephen D. Shell, Columbus

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MIAMI (Troy)
Chong Won Lim

MONTGOMERY (Dayton)
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Don E. Gregory

STARK (Louisville)
Zenaida A. Chughtai

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Evaluation of an Attenuated, Live, Bivalent, Influenza Vaccine in Children

Dennis L. Burech, M.D.
Katalin I. Koranyi, M.D.
Ralph E. Haynes, M.D.

An attenuated, live, bivalent influenza vaccine was administered intranasally to 40 children. No untoward reactions occurred during the 16-week surveillance period. Serologic conversion occurred in the majority of children with prevaccination HI titers of <64 to influenza A but not to influenza B. Although the most likely explanation is that type B component was no longer active at the time of administration, further studies will be required to evaluate the usefulness of the vaccine.

INFLUENZA CARRIES a significant complication rate in susceptible populations such as infants, those debilitated by age or underlying disease, and those living in crowded conditions. During epidemics, 50 percent of the population at risk may experience illness, depending on the degree of crowding and the state of immunity.¹ Influenza A reappears in two- to three-year cycles, while influenza B reoccurs every four to six years.¹ Influenza C has not been implicated in any epidemics, but it may cause sporadic infections.² Secondary complications in children include otitis media, mastoiditis, sinusitis, secondary bacterial pneumonia, abscess, myocarditis, and empyema.¹ The occurrence of Reye's syndrome during outbreaks of influenza A and B suggests an association between these diseases.³⁻⁵ Spontaneous mutations in influenza virus A, and occasionally in influenza virus B, make difficult the preparation of a vaccine containing the antigens necessary to protect against expected epidemics. Currently available, bivalent, inactivated, influenza vaccines given subcutaneously may produce pain at the injection site and may evoke systemic reactions such as fever, myalgia, and pharyngitis, in some recipients. In addition, inactivated influenza vaccine given subcutaneously does not stimulate secretory IgA antibody production as well as experimental infection with in-

fluenza virus does.⁶ Protection against infection with influenza and other respiratory viruses is more complete when associated with secretory IgA antibody than with serum antibody contained in the IgG fraction.⁷ For these reasons, currently available influenza vaccines are not entirely satisfactory.

The administration of a live, attenuated vaccine intranasally may be of value in preventing influenza. To be effective, such a vaccine should be devoid of significant reactions; it must stimulate the formation of specific antibodies. This study, approved by the Human Subjects Research Committee at Columbus Children's Hospital, was undertaken to determine the antigenicity and the toxicity of a bivalent, live, attenuated, influenza-virus vaccine given intranasally to children.

Population

Forty children in a local children's home, ages ranging from 11 to 17 years, had a complete medical history recorded and physical examination done prior to vaccination and within 48 hours after completion of the study.

Dr. Burech, Columbus, Fellow, Infectious Diseases, Children's Hospital; and Clinical Instructor in Pediatrics, The Ohio State University College of Medicine.

Dr. Koranyi, Columbus, Fellow, Infectious Diseases, Children's Hospital; and Clinical Instructor in Pediatrics, The Ohio State University College of Medicine.

Dr. Haynes, Columbus, Director, Infectious Disease Division, Children's Hospital; and Professor of Pediatrics and Medical Microbiology, The Ohio State University College of Medicine.

Reprint requests to Columbus Children's Hospital, 561 S. 17th St., Columbus, Ohio 43205 (Dr. Haynes).

Submitted March 8, 1976.

Informed consent was obtained from the legal guardians of the children prior to initiating the study. Five drops of a vaccine containing live, attenuated, influenza A virus and influenza B virus were administered into each nostril, with the patient in the supine position with head extended. All patients were observed for immediate reactions (sneezing, gagging, taste), and all were examined daily for five days after immunization for evidence of respiratory disease. One half of the study population was given a booster dose of the vaccine 15 days after the first dose. Blood was drawn for hemagglutination-inhibition (HAI) antibodies prior to and on the 30th day following initial immunization. To detect untoward reactions or respiratory disease, surveillance was continued in the study population for a 15-week period.

Serologic Techniques

Determination of Hemagglutination (HA) Titer. — Serial twofold dilutions of the influenza virus prototypes A, strain MRC-7, type H₃N₂, and strain BHK 873, supplied by Smith Kline and French Laboratories, were carried out in phosphate buffer saline (PBS) solution pH 7.2, using 0.25 ml volume in standard serologic tubes. A volume of 0.25 ml of PBS, followed by 0.25 ml of 0.5 percent chicken red-blood-cell suspension, was added to each tube with thorough mixing. Controls for red cells and diluents were used. Incubation was carried out at room temperature for one hour. The highest virus dilution showing complete hemagglutination contained one hemagglutinating unit.

Elimination of Nonspecific Inhibitors from Sera. — A volume of 0.1 of serum was mixed with 0.5 ml of reconstituted receptor-destroying enzyme (RDE).⁸ This mixture was incubated at 37 C for 18 hours and afterward heated at 56 C for 30 minutes. After cooling, a volume of 0.1 ml of 50 percent chicken red-blood-cell suspension was added at 4 C for one hour to eliminate agglutinins for chicken red-blood-cells. After centrifugation, the supernatant, which constituted treated serum at a dilution of 1:6, was harvested. This was diluted further to obtain a 1:8 initial dilution.

Determination of the Hemagglutination-Inhibition Titer. — Serial twofold dilutions of the treated serum, starting at the 1:8 dilution, were prepared in PBS solution. From each dilution, 0.25 ml was mixed with 0.25 ml of viral suspension containing four hemagglutinating units and kept for one hour at room temperature. A volume of 0.25 ml of 0.5 percent chicken red-blood-cells suspension in PBS was added. The mixture was incubated at room temperature for one hour. Appropriate controls for each serum, the red-blood-cell suspension, and the diluent were incorporated into the test. Back titration of the working dilution containing four hemagglutinating units was performed. The hemagglutination-inhibition titer of each serum was expressed as the highest dilution of the serum inhibiting four hemagglutinating units of influenza antigen.

Live, Attenuated, Influenza Vaccine for Intranasal Administration. — Influenza vaccine containing live, attenuated virus types A and B has been tested in monovalent

forms.⁹ The type A component of the study vaccine ("Alice strain" vaccine) is a recombinant of strains A/England/42/72 and A/PR8/34 and has been described previously.¹⁰ The type B component ("R75 strain" vaccine) is a recombinant of B/Russia/69 strain and B/Hong Kong/5/72 strain. It has been passed 15 times in embryonated hens' eggs, possesses the antigenic components of B/Hong Kong/5/72, and has a permanent inhibitor-resistant marker. The bivalent vaccine was maintained in the lyophilized form and reconstituted just prior to use. Each dose contained 10^{7.4} EID₅₀ and 10^{7.2} EID₅₀ of types A and B, respectively. (EID = egg infectious dose.)

Results

Thirty-seven of the 40 patients completed the 30-day study. Six of the eight children who had prevaccination HI titers to influenza A of <64 responded with a fourfold rise in antibody. Eight of the remaining 29 children with prevaccination HI titers to influenza A ≥64 also developed a fourfold antibody response. However, only three children developed fourfold rises in HI antibodies to influenza B despite preimmunization titers in all children of <64, and 35 of 37 children with titers ≤8. The five-day period following immunization was free of untoward reactions, and no patients had significant fever, headache, or myalgia.

Discussion

Serologic conversion occurred in the majority of children with prevaccination HI titers of <64 to influenza A but not to influenza B. Other investigators also have found the "Alice strain" (type A) to be immunogenic in children when given intranasally in a monovalent preparation.¹⁰ There may be several reasons for lack of seroconversion from the B component. Serum antibody production may not always follow vaccine administered intranasally.^{11,12} The replication of the attenuated type B influenza virus also may be blocked by the presence of other interferon-producing respiratory viruses, perhaps even by the type A virus. None of our patients had clinical evidence of concurrent, upper respiratory disease. All patients were kept in supine position with head extended for one minute and almost all complained immediately of a "funny" taste. The virus may not have been adsorbed, and perhaps infection of the respiratory tract did not occur. The most likely explanation is that the type B component was no longer active at the time of administration. Loss of antigenicity in some lots of inactivated influenza vaccine has been reported.¹³ Further studies, such as titration of the type B component of the vaccine, production of secretory antibodies, and challenge of recipients, will be required to fully evaluate the usefulness of this vaccine.

References

1. Mogabgab WJ: *Communicable and Infectious Diseases*, Top FH Sr, Wherle FP (eds), St. Louis, C V Mosby, 1972, p 330.
2. Behbehani AM: *Human Viral, Bedsonial and Rickettsial*

Diseases; a Diagnostic Handbook for Physicians. Springfield, Chas C Thomas, 1972, p 209.

3. Riley HD: Reye's syndrome (editorial). *J Infect Dis* 125:77-81, 1972.
4. Hall BD, Hughes WT, Kmetz D: Reye's syndrome: an association with influenza A infection. *J Ky Med Assoc* 67:269-271, 1969.
5. Corey L, Rubin RJ: *Reye's Syndrome*, Pollack JD (ed), New York, Grune and Stratton, 1975, p 181.
6. Mann JJ, Waldman RH, Togo Y, et al: Antibody response in respiratory secretions of volunteers given live and dead influenza virus. *J Immunol* 100:726-735, 1968.
7. Bellanti JA: Biologic significance of the secretory γ A immunoglobulins. *Pediatrics* 48:715-729, 1971.
8. Burnet FM, Stone JD: The receptor-destroying enzyme of *V. cholerae*. *Austr. J Exper Biol Med Sci* 25:227-233, 1947.

9. Smith Kline & French Laboratories' Investigational Use Circular: *Live Attenuated Influenza Vaccine Types A and B*. Philadelphia, 1974.
10. Hall CB, Douglas RG, Fralonardo SA: Live attenuated influenza virus vaccine trial in children. *Pediatrics* 56:991-998, 1975.
11. Waldman RH, Kasel JA, Fulk RV, et al: Influenza antibody in human respiratory secretions after subcutaneous or respiratory immunization with inactivated virus. *Nature* 218:594-595, 1968.
12. Lauteria SF, Kantzler GB, High PC, et al: An attenuated influenza virus vaccine: reactogenicity, transmissibility, immunogenicity, and protective efficacy. *J Infect Dis* 130:380-383, 1974.
13. D'Alessio DJ, Cox PM, Dick EC: Failure of inactivated influenza vaccine to protect an aged population. *JAMA* 210:485-489, 1969.

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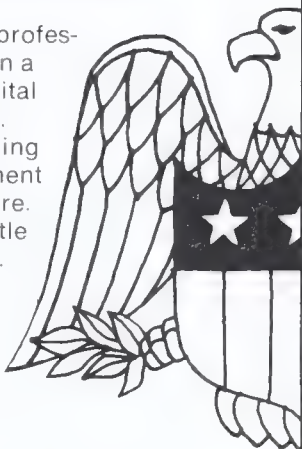
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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Alcoholism—Three Points to Remember

Philip E. Hinkle, Columbus

Although alcoholism has existed since the origin of mankind, physicians (like society in general) have been unduly slow in recognizing it as a primary disease entity.

In medical school and in the practice of clinical medicine, attention is focused on the isolated physical complications of alcohol abuse. The patient is doomed to continued physical and psychological illness because the primary problem goes unattended.

Today, successful treatment programs exist which treat the source of these physical complications — alcohol abuse.

We must have a radical revamping of our attitudes regarding alcoholism, our educational practices concerning it, and our therapeutic approach to this dreadful disease.

Editor's Note: The author was a medical student and in the last months prior to graduation from The Ohio State University College of Medicine at the time this article was submitted for publication. He was under the guidance of Charles N. Hoyt, M.D., Department of Preventive Medicine, The Ohio State University College of Medicine; and Medical Director of Alcoholism Services Dept., Riverside Methodist Hospital. The Journal is desirous of encouraging medical students to participate in our educational publications.—R.L.M.

Who could have foretold, from the structure of the brain, that wine could derange its functions?

Hippocrates (c460-c360 B.C.)

IN DISCUSSIONS CONCERNING the "drug problem," one hears repeated mention of those dreaded chemicals which are now household words—heroin, LSD, barbiturates, and "speed." Yet, among a group of people having a drink before dinner, a frank discussion of the most commonly used and perhaps most dangerous psychoactive drug—alcohol—is not heard. Alcohol is so deeply ingrained into our culture that most individuals do not even consider it a drug. The dangers of alcohol abuse have been minimized, and its victims have been ridiculed or, at best, ignored for years. Audiences laugh as the comedian imitates a "drunk" seeing "pink elephants" and suffering from other hallucinatory phenomena caused by alcohol withdrawal. The disease concept of alcoholism and the realization that it is as inappropriate to ridicule

an alcoholic as it is to ridicule a cancer victim have not gained widespread public acknowledgment.

This paper is written to stress three major points: First, alcoholism is not a moral issue but a genuine disease process. Second, we have failed for years to recognize the disease concept of alcoholism and, thus, we have failed to treat it adequately. Finally, this is an area in which prevention is the best and most effective treatment of the disease.

It is impossible to say with complete accuracy how many alcoholics there are in America. Of the more than 200 million citizens, approximately 100 million consume alcoholic beverages. Of these, approximately 1 in 12 is an alcoholic. The National Institute of Alcohol Abuse and Alcoholism estimates the number of alcoholics in the United States to be nine million.¹ Since the American family usually has at least four members, this disease affects the lives of over 30 million Americans. In addition, the complex web of alcoholism snares millions of innocent bystanders each year. The National Safety Council points to alcohol as the major factor in approximately one-half of fatal automobile accidents. The majority of these stem from alcoholism, not social drinking. An alcoholic employee misses on the average of 22 more working days each year than the nonalcoholic and suffers twice the number of accidents. "In general hospitals, depending on the locale, at any time on the general medical and surgical wards from 25 to 50 percent of the patient population, regardless of their diagnoses, have alcohol complications."²

While the definitions of alcoholism vary, as do the epidemiologic criteria, the magnitude of the problem is evident. The suffering, unhappiness, and tragedy that

alcoholism inflicts on its victims and their families is enough to impress even the most indifferent observer.

An alcoholic has been lightly defined as a man who drinks more than his own doctor.

Alvan L. Barach³

While there have been hundreds of definitions of alcoholism proposed, none has become universally acceptable. Most definitions reflect the particular orientation of their author and, as a consequence, are objectionable to many. This is true with a number of other diseases; the minimum criteria necessary to establish the diagnosis beyond doubt often is disputed. However, this does not deny the existence of the disease (eg, collagen vascular diseases), nor should it with alcoholism. The following broad definition is helpful: "Alcoholism is an illness characterized by preoccupation with alcohol and *loss of control* over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency toward relapse. It is typically associated with physical disability and impaired emotional occupational, and/or social adjustments. . . ."¹

Alcoholism is recognized as a drug dependence and, while it may be of varying severity, it always grows to interfere with the patient's health and social adjustments. As the disease process advances, the alcoholic becomes more preoccupied with alcohol to the exclusion of his family, friends, and career. His growing physical addiction presses him to spend larger and larger amounts of his time and resources in obtaining, ensuring, and, later, concealing his supply. Unconsciously, his life becomes oriented around his growing physiologic and psychologic dependence upon alcohol. Whatever his previous level of social and personal functioning, he is less effective when he is either constantly intoxicated or suffering alcohol withdrawal symptoms. He becomes as physically and socially debilitated as the better-known opiate addict. If he is unfortunate, he will lose his job, all his possessions, and will be abandoned by his family. He then is forced to drink cheaper alcohol and live alone in the cheapest of housing. Everything previously valued is given up in order to feed an addiction which demands increasing amounts of alcohol. If he falls down the socioeconomic ladder to this degree, he becomes the "skid row bum" who fits the old public stereotype of the alcoholic. Yet only 3 percent of alcoholics fall to these extreme depths of economic and social poverty. Most alcoholics are able to avoid the most devastating socioeconomic consequences of their disease. However, they are not able to avoid the progressing physical addiction and general health deterioration. There are millions of such hidden alcoholics. Like many diseases, alcoholism is no respecter of age, race, sex, social, or economic standing. There are thousands of alcoholics, including respected professionals, who hide their addiction. Housewives, who stay at home during the day, often are able to hide their disease for years since they do not have to endure constant public inspection.

Consequently, we see that one need not be a classic "skid row bum" to be afflicted with alcoholism.

One of the problems in the recognition of the disease concept of alcoholism is the long-standing controversy over the etiologic factors. Despite repeated attempts to discover one specific cause for alcoholism, none has been found. Heredity, environment, physiologic or psychologic factors are not sufficient to consistently account for the origin and development of alcoholism.

The more you drink, the more you crave.

Alexander Pope, in *Satires and Epistles Imitated*

First the man takes a drink, then the drink takes a drink, then the drink takes the man.

Japanese Proverb

Alcohol is a drug which produces profound physiologic effects when used in excess, and dependency or physical addiction may follow. Yet the majority of those who drink alcohol do not become addicted. It is still uncertain as to whether the alcoholic may suffer from a physiologic aberration which makes him acutely sensitive to the drug, alcohol. There is much data to indicate that physiologic factors contribute to the progression of the disease; there is no evidence to indicate that this is the *main* factor in the onset of the disease.

It is generally held that psychologic factors play a role in the disease process. Some contend that the psychologic factor is the primary pathology and that alcoholism is the resulting symptom. Others contend that alcoholism is a learned response taught to its victims by their environment. Still others contend that the poor psychologic condition of the alcoholic is the result of his alcoholism—not a factor in its etiology. They contend that long periods of alcohol abuse have affected his ability to think clearly, secondary to the toxic drug effect. Some researchers point to sociologic factors as the major ones to consider. Different cultures display differing attitudes toward alcohol, ranging from total abstinence to extreme permissiveness. When total abstinence is the common attitude, alcoholism is fairly rare. When the culture is ambivalent toward the use of alcohol, alcoholism is a common problem. Yet these are generalizations to which exceptions can be found. "Finally, the point bears repetition: it is generally accepted that alcoholism stems from not a single cause, but from a complicated interplay of physiological, psychological, and sociological causes."¹

Nothing is more unhealthful than too much wine.

Latin Proverb

A common sight on a general medical ward is that of the alcoholic whose years of excessive drinking have caused irreparable, advanced cirrhosis of the liver. He has collapsed after a typical drinking bout in which his physical craving for alcohol was so great that he drank continually and ate little or nothing for weeks at a time. This patient is hospitalized and forced to give up alcohol

during this time. He is given a good diet with vitamin supplements and kept at bed rest. Usually, and to a certain extent, he will recover slowly from his debilitated state until, from a medical standpoint, he is ready for release. At this time, his physician instructs him never to drink alcohol again, warning him that if he does, he faces certain illness and probable death. The alcoholic leaves the hospital promising everyone, including himself, that he will never drink alcohol again. But for a period of 20 or more years, his life style has been oriented around alcohol. He is psychologically and physically addicted; his alcoholism has progressed markedly. He is able to abstain for a few weeks or even a few months before he takes his first drink. To his own amazement and to the surprise of others around him, he is drinking more than ever in a few days. He is not drinking because he has low moral standards or because he is merely seeking pleasure. He drinks because he has totally lost control; he is physically and psychologically addicted to a drug over which he has absolutely no power.

*Inflaming wine, pernicious to mankind,
Unnerves the limbs, and dulls the noble mind.
Homer (ca850 B.C.), in Iliad VI 261*

Traditionally, we have maintained a judgmental and moralistic attitude toward the alcoholic and have erroneously labeled his disease as a "self-inflicted" illness. Although it is a disease which has existed since the origin of mankind, we have been unduly slow in recognizing alcoholism as an illness—indeed, a treatable illness. We have avoided alcoholics with the belief that their problem was hopeless. Although the ancient Greeks knew of alcoholism, it was not recognized as an illness by the American Medical Association until 1956. Even though the American Medical Association, the American Psychiatric Association, and the American Hospital Association have all recognized alcoholism as an illness, many hospitals will not admit patients under the correct diagnosis of alcoholism. A cover diagnosis, such as "gastritis" or "cirrhosis," must be used even when it is clear that the chief problem and causative factor of the diffuse organic pathology is alcohol abuse. The disease is not confined to the gastric mucosa or the regenerating hepatic lobules. While the physical complications are many, varied, and devastating, they all can be averted by preventing the etiologic factor, alcohol abuse.

We have failed to recognize alcoholism because we have not been educated sufficiently. A physician is a member of a society; thus, to a certain extent, his views are bound to reflect those of the society as a whole. Yet this

never is an excuse for medical mismanagement of a patient's illness. Medical schools have neglected to stress the concept of alcoholism as a disease, despite its overwhelming incidence. The complications of alcohol abuse are dealt with individually; the treatment for isolated disease states, eg, anemia secondary to folate deficiency, is discussed without regard to the patient as a whole. Thus, it is easy for one to leave medical school fully able to describe, recognize, and treat the physical complications of alcohol abuse and never really consider the disease concept of alcoholism. One may not realize that there are successful treatment programs that treat the source of the physical complications—alcohol abuse. By repeatedly treating the secondary effects of alcoholism and then sending the patient out of the hospital with only the advice "not to drink again," the physician dooms the patient to a continued career of alcoholism and physical illness. This is true because the primary problem went untreated. x

In the previously mentioned case of the alcoholic with liver cirrhosis, hospitalization was required for an acute condition. The best therapy available was a good diet with supplemental vitamins and total abstinence from alcohol. While this is the best treatment for advanced liver disease, it also is the most effective prevention course available! Had this therapy been effected 20 years earlier, along with appropriate follow-up therapy, the disease would have been prevented. We concentrate the overwhelming bulk of our attention in medical school and clinical medical practice on the treatment of complications of alcohol abuse. Yet by this time, it often is too late to help the patient to any significant degree. As with other diseases, a prolonged waiting period before initiation of therapy is disastrous and usually fatal. "Alcoholism costs more in suffering and money than any other illness. Yet as a nation our treatment approach can only be described as deplorable."⁴ We must have a radical revamping of our attitudes regarding alcoholism, our educational practices concerning it, and our therapeutic approach to this dreadful disease. The emphasis must shift to prevention.

References

1. American Medical Association: *Manual on Alcoholism*. Chicago, 1973, pp 3-5, 25.
2. *Medical Complications of Alcohol Abuse. Summary of the 1973 AMA Washington Conference Sponsored by the Committee on Alcoholism and Drug Dependence*, AMA, Chicago, pp 4-48.
3. Barach: Extramedical influence of the physician. *JAMA* 181:393-395, 1962.
4. Hoyt CN: Alcoholism. A review and overview. *Ohio State Med J* 66:674-678, 1970.

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An Overlooked Necessity in Geriatrics

William R. Chambers, M.D.

MANY ARTICLES HAVE been written about the so-called Golden Age and the failure of sincere efforts on the part of devoted people to really bring joy to the hearts of our senior citizens. After four years' intensive study of geriatrics, stimulated by the duties of acting as clinical director for the geriatric section at Longview State Hospital, some very frightening facts became quite apparent. Fortunately, however, one solution dawned upon me. We are being told that, in the too near future, our nonworking population (persons under 18 and over 65 years old) will equal the number of employables (persons between 18 and 65 years old). It will be an impossible task for the employables to support an equal population of unemployables at even marginal standards.

I recently visited two middle-class, geriatric communities. Both had beautiful, well-kept grounds, an immaculate nine-hole golf course, swimming facilities, and a large recreational building. Although it was a beautiful day, there were only four golfers on one of the courses. In the first room we entered in the recreation building, we noted eight ping-pong tables; only one was in use. After several such observations, we located one of the managers and asked where all the old people were, and we were directed to a large room nearby. Here, men and women were working almost shoulder-to-shoulder shaping, polishing, and framing beautiful, variegated colored stones collected from nearby mountains. They were making pendants, rings, bracelets, necklaces, and other beautiful things, with great pride. One man announced he was making his pendant as a graduation present for his granddaughter.

In the same spirit, in another room, people were fashioning artistic wall decorations, trays, and other items from wood, under the direction of a skilled wood worker.

Even here, some little thing seemed to be lacking. The supervisor again was contacted and asked if he knew the places where the senior citizens were the happiest. He directed us to a building at a nearby university, where we found a very large room packed with men and women, boys and girls. Bits of small machinery plus tools unfamiliar to us were scattered over a large desk. Young people were working with older people, and there was a great deal of laughter, good humor, and satisfaction. It was a class in learning to assemble small engines. Most of

the people there were loath to talk because they were so busy with what they were doing. However, one older man and one college student did take time to converse. They seemed happy to be working together with a goal of producing something very useful. The college student was asked how he could be patient with the comparative slowness of his elderly partner. His answer was: "Sure, man! I do go faster and I do know more about the new engines; but I decide what I want to do and my older partner here, with 40 years' experience in this work, shows me how to do it in half the time."

It has recently been stated that there are 88 colleges and universities in Ohio that offer part- or full-time courses in geriatrics. If America is to remain strong in the future, elderly persons who are still alert, capable, and healthy must make their contributions to the gross national product even though they may be able to work only half time. Otherwise, we can expect eventual rebellion in some form from the overburdened half of the population aged 18 to 65 years. We suggest that, by using Ohio's 88 colleges and universities to promote interest in geriatrics, we can make a concerted effort to unite the abilities of the old and the young in useful, needed productivity. We believe the capable senior citizen is sincerely happy only when he feels needed and useful. Let us give thought to a program that not only will keep them happy, but will add to the wealth of the nation in the future.

The one essential ingredient that the college situation had, which made it superior to the previous facilities, was the opportunity to work with younger people. Senior citizens are not completely happy if sequestered in old age communities. An added advantage is the promotion of communication between the two groups.

Dr. Chambers, Cincinnati, was Clinical Director, Geriatric Section, Longview State Hospital; and Assistant Clinical Professor of Psychiatry, University of Cincinnati College of Medicine, at the time this article was written. He retired May 31, 1976 from the clinical directorship.
Submitted August 25, 1975.

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CHARLES E. BOST, M.D., Cleveland; University of Cincinnati College of Medicine, 1929; age 74; died April 15; member OSMA and AMA.

ALFRED V. BOYSEN, M.D., Cleveland; University of Iowa College of Medicine, 1921; age 79; died April 4.

SHERWOOD A. CHAMBERLAIN, M.D., Naples, Florida; University of Louisville School of Medicine, 1932; age 70; died April 8; member OSMA and AMA.

MARIANO M. DIAZ, M.D., Ironton; University de la Habana, La Habana, Cuba, 1937; age 70; died April 28; member OSMA and AMA.

NANCY E. FINNEY, M.D., Brookville; Ohio State University College of Medicine, 1923; age 85; died March 30; member OSMA and AMA.

ROBERT LEE GOYDES, M.D., Cleveland; Ohio State University College of Medicine, 1959; age 43; died April 12; member OSMA and AMA.

J. ROBERT HAWKINS, M.D., Cincinnati; University of Cincinnati College of Medicine, 1939; age 64; died December 10, 1975; member OSMA and AMA.

ALBERT CHAS. HOWELL, M.D., Tipp City, Ohio; Ohio State University College of Medicine, 1963; age 41; died April 27; member OSMA and AMA.

CHARLES R. KELLER, M.D., Mansfield; University of Michigan Medical School, Ann Arbor, 1915; age 92; died May 8; member OSMA and AMA.

CARL W. KOEHLER, M.D., Cincinnati; University of Cincinnati, College of Medicine, 1930; age 70; died July 9, 1974; member OSMA and AMA.

CHARLES H. LEECH, M.D., Bethel, Kentucky; University of Cincinnati College of Medicine, 1922; age 78; died March 24; member OSMA and AMA.

MARTIN P. MAHRER, M.D., Miami, Florida; Royal Hungarian University of Budapest, 1915; age 82; died April 20.

MARCUS J. MAGNUSSEN, M.D., Gallipolis; University of Iowa College of Medicine, 1935; age 69; died April 4; member OSMA and AMA.

ANTHONY MATUSKA, M.D., Cincinnati; University of Cincinnati College of Medicine, 1917; age 82; died June 13, 1974; member OSMA and AMA.

RICHARD C. MILLER, M.D., Dayton; St. Louis University School of Medicine, 1935; age 65; died April 19; member OSMA and AMA.

CLARKE P. PENNINGTON, M.D., Sarasota, Florida; University of Louisville School of Medicine, 1936; age 75; died June, 1973; member OSMA and AMA.

YORK N. PITKIN, M.D., Islamorada, Florida; Case Western Reserve University School of Medicine, 1936; age 69; died April 12.

HARRY N. ROBACK, M.D., Cleveland; McGill University Faculty of Medicine, Toronto, Ontario, 1934; age 74; died April 20; member OSMA and AMA.

VERNON B. ROBERTS, M.D., Cincinnati; University of Cincinnati College of Medicine, 1920; age 81; died November 22, 1975; member OSMA and AMA.

PAUL S. ROSS, M.D., Columbus; Yale University School of Medicine, New Haven, 1931; age 70; died April 6; member OSMA and AMA.

STUART A. SCHLOSS, M.D., Cincinnati; Uni-

versity of Cincinnati College of Medicine, 1935; age 66; died November 29, 1975; member OSMA and AMA.

JULIUS SHAMANSKY, M.D., Bya Harbor, Island, Florida; Ohio State University College of Medicine, 1922; age 79; died April 14; member OSMA and AMA.

ROBERT R. SOMER, M.D., Grove City; Ohio State University College of Medicine, 1945; age 55; died April 5; member OSMA and AMA.

CECIL STRIKER, M.D., Cincinnati; University of Cincinnati, College of Medicine, 1921; age 78; died April 4; member OSMA and AMA.

CARROLL F. TATUM, M.D., Akron; Baylor College of Medicine, Huston, 1942; age 64; died February 4; member OSMA and AMA.



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OSMA Testimony on Medicaid Cost Containmentment

(Editor's Note: Robert N. Smith, M.D., Past President of the OSMA, presented the following testimony on behalf of the OSMA at hearings of the Select Committee on Welfare of the Ohio Senate. The Committee heard this testimony on June 16, 1976, as a part of its investigation into the Medicaid program.)

Mr. Chairman and Members of the Committee, my name is Robert N. Smith. I am a practicing physician in Toledo, and a past president of the Ohio State Medical Association. I have been asked to speak with you concerning cost containment proposals you are considering today regarding the Medicaid program. My remarks will be rather general in nature because of the unfortunate shortness of the time period allotted. A specific written response will be submitted to you and to your staff for consideration.

The Ohio State Medical Association feels very strongly that the proposal you have before you to develop a program of a fiscal intermediary to administer Medicaid in the State of Ohio is an excellent one and may, in fact, provide the best alternative to solve most of the current problems. The Medicaid program is probably the most highly regulated of any program Ohio's physicians and other health care providers must deal with. This in and of itself may be part of your total program. The use of a fiscal intermediary could very well provide management techniques and auditing procedures which will at the same time lessen the burdens of both the provider and recipient while increasing the ability to provide quality health care to Ohio's needy.

Studies show that Medicare Part B carriers have lower administrative costs per claim than does government.

Cost containment is a theory under which this committee is forced to operate. However, Ohio's physicians wish to point out that what is being sought probably is "claims efficiency," not cost containment. Ohio's needy deserve the kind of quality care that Ohio's physicians can and do provide. State government programs such as Medicaid must be designed to encourage quality health care delivery. Ever-increasing regulation and, indeed, the threat of ever-increasing cost containment, may, in fact, begin to drive the practicing physician out of the Medicaid system. Many physicians in Ohio will quickly point out that it is more expensive to deal with a Medicaid patient than with a regular private patient because of increased paper work, slowness in payment, reduced payments, and because these patients tend to be more demanding.

An example of a problem of containment is the suggestion that payments for physician visits be limited to two to four visits per month. When Ohio physicians agree to accept Medicaid patients, or for that matter when they agree to take *any* patient, the physician is legally and ethically required to provide the best care possible for that patient. In many cases, adequate care may require

more than four, perhaps more than 20, visits per month. Arbitrary containment systems, may, in fact, cause a decline in quality health care. Patients cannot be fashioned to conform to regulations. This Committee should bear that in mind.

The federal government and state agencies have indicated to you and to the media that there exists some fairly widespread fraud and abuse in the Medicaid system. Ohio's physicians and the Ohio State Medical Association feel very strongly that if and when fraud of this type is shown to include questionable actions on the part of a physician, charges should be made and prosecution carried out promptly and forcefully. In addition, the Ohio State Medical Association very much desires to investigate such cases and hereby repeats a long-standing request that any cases of physician fraud be brought directly to the Association's attention. This would mean that a physician who is determined to be participating in fraudulent activities may be removed from membership in the OSMA. Also, he may be prosecuted under language which this Legislature enacted last year in H.B. 682, to permit revocation of his license to practice medicine.

Section 4731.22 (B) (9) of the Ohio Revised Code provides that the State Medical Board may revoke the license of a physician for obtaining or attempting to obtain money or anything of value by fraudulent misrepresentations in the course of treatment. The authority should be used to remove from the practice of medicine any individual guilty of fraud or abuse in the Medicaid system—in fact, in any system—and the OSMA is more concerned than the Legislature or the public.

While it is true that national estimates range from 5 percent to 15 percent in the amount of fraud and abuse in the Medicaid program, there is no reason to believe that Ohio's health care providers are abusing the system at this level. When audits now being considered are completed and cases of physician fraud clearly identified, the Ohio State Medical Association will join with you in encouraging the State Medical Board to remove licenses and in asking the courts to punish the guilty.

Your Committee is considering a wide variety of alternatives to solve the current Medicaid funding crisis in Ohio. Because of time limitations, I am not going to be able to respond to every one of these alternative proposals. But I will make a few remarks on behalf of Ohio's physicians in regard to a few of the key issues. I again emphasize that the Ohio State Medical Association strongly feels that the establishment of a viable fiscal intermediary is the best mechanism to provide ongoing savings in the Medicaid program. There is no question that the private sector within our society is better able to manage programs, especially programs of this magnitude, than is the government. It is perfectly apparent that the Medicaid program, which is operated by fiscal intermediaries, is more efficient and enjoys better acceptance among the

(continued on page 451)

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Index to Actions on Resolutions

Report of Resolutions Committee No. 1 begins on page 408; Resolutions Committee No. 2 on page 412; Resolutions Committee No. 3 on page 418.

Note: This index is for reference purposes only and is not a part of the Official Proceedings of the House of Delegates.

RESOLUTION NO. . . .	SUBJECT AND SPONSOR	REFERRED TO RESOLUTIONS COMMITTEE NO. . . .	RESOLUTION NO. . . .	SUBJECT AND SPONSOR	REFERRED TO RESOLUTIONS COMMITTEE NO. . . .
01	Parliamentarian (Academy of Medicine of Toledo)	No. 2	25	P.S.R.O. (Huron County Medical Society)	No. 2
02	Citizenship Requirements (Lorain County Medical Society)	No. 2	26	National Health Insurance (Huron County Medical Society)	No. 2
03	Adding Faculty to Membership Category (OSMA Council)	No. 2	27	The Patient Speaks (Huron County Medical Society)	No. 3
04	Advertising (Academy of Medicine of Cleveland)	No. 3	28	Free Enterprise Coalition Citizens-Physicians- Hospital Administrators-Boards of Trustees (Huron County Medical Society)	No. 3
05	Regulation of Emergency Ambulance Services (Academy of Medicine of Cleveland)	No. 3	29	Amendment to House Bill 682 (Academy of Medicine of Cincinnati)	No. 1
06	Protection Against Frivolous Lawsuits (Academy of Medicine of Cleveland)	No. 1	30	Medical Liability Insurance Premiums Related to Exposure (Academy of Medicine of Cincinnati)	No. 1
07	Confidentiality (Academy of Medicine of Cleveland)	No. 2	31	Disclosure of Professional Liability Statistics (Academy of Medicine of Cincinnati)	No. 1
08	Provider-Owned Insurance Company (Academy of Medicine of Cleveland)	No. 1	32	Commendation for Richard Meiling, M.D. (Academy of Medicine of Cincinnati)	No. 3
09	Retired Physician Exempt from Stabilization Reserve Fund (Academy of Medicine of Cleveland)	No. 1	33	Establishment of Culture Committee (Academy of Medicine of Cincinnati)	No. 3
10	Automatic Issuance of Reporting Endorsement by JUA (Academy of Medicine of Cleveland)	No. 1	34	Physicians Registration (Academy of Medicine of Cincinnati)	No. 2
11	OSMA Sponsored Courses in English and Basic Sciences for Foreign Medical Graduates (Academy of Medicine of Cleveland)	No. 3	35	Citizenship Requirements (Academy of Medicine of Columbus)	No. 2
12	Financing Countersuits (Trumbull County Medical Society)	No. 1	36	Abortion (N. M. Camardese, M.D., Delegate Huron County Medical Society)	No. 2
13	"Assignment" Opposed (Lake County Medical Society)	No. 3	37	Congratulations to AMA (Ross County Medical Society)	No. 3
14	Smoking Ban in Hospitals (Academy of Medicine of Cleveland)	No. 3	38	Failure of PSRO (Ross County Medical Society)	No. 2
15	OSMA Position on Public Law 93-641 (Academy of Medicine of Cleveland)	No. 2	39	Inform the Public About Professional Liability (Academy of Medicine of Cleveland)	No. 1
16	Official Representative of Organized Medicine (Academy of Medicine of Cleveland)	No. 3	40	Determination of Death (Academy of Medicine of Cleveland)	No. 3
17	Policyholder Consent to Settlements (Academy of Medicine of Cleveland)	No. 1	41	Licensing of Physician's Assistants (Academy of Medicine of Cleveland)	No. 3
18	JUA to Offer Occurrence Contracts (Academy of Medicine of Cleveland)	No. 1	42	Maximum Allowable Cost Regulations (OSMA Council)	No. 3
19	Clarification of Statute of Limitations (Academy of Medicine of Cleveland)	No. 1	43	Redistricting the Ohio State Medical Association (Holmes County Medical Society)	No. 2
20	Impartial Arbitration (Academy of Medicine of Cleveland)	No. 1	44	Malpractice Lawsuits (Fourth Councilor District)	No. 1
21	Development of Professional Liability Data (Academy of Medicine of Cleveland)	No. 1	45	Special Assessment for Proposed Countersuits (Second Councilor District)	No. 1
22	Absent Delegates (Thomas F. Moriarty, M.D., Member, Henry County Medical Society)	No. 2	46	Persecution of Religious Minorities (Second Councilor District)	No. 3
23	Hospital Discharge Data Acquisition (Huron County Medical Society)	No. 2	47	Nomination and Election of District Councilors (Implementation Resolution 37-75)	No. 2
24	Direct Billing (Huron County Medical Society)	No. 2			

Proceedings of the House of Delegates

1976 Annual Meeting

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 6:30 PM, Sunday, May 9, 1976, at the Cincinnati Exposition Center, Cincinnati, with President Maurice F. Lieber, presiding.

The Invocation was offered by Fr. John W. Lasca, S.J., of the Gesu Church, Toledo.

A special Bicentennial Program followed, consisting of the presentation of colors; choral renditions presented by the Montgomery County Medical Society Glee Club, directed by Dr. W. J. Lewis; and readings from leaders of the American Revolution, arranged by Dr. John E. Albers.

Dr. Neal N. Earley, Cincinnati, President of the Academy of Medicine of Cincinnati, welcomed the delegates and guests to Cincinnati.

REPORT ON DELEGATES PRESENT

Dr. Andrew J. Weiss, Cincinnati, Chairman of the Credentials Committee, reported that out of 176 delegates eligible to vote, 163 were seated. A number of alternate-delegates, guests, officers of county medical societies, and executive secretaries were in attendance.

1975 MINUTES APPROVED

The minutes of the 1975 sessions of the House of Delegates, as published in the July 1975 issue of *The Ohio State Medical Journal* were approved by official action.

PRESIDENT'S ADDRESS

Mr. Page then introduced President Maurice F. Lieber, Canton, who delivered his Presidential Address entitled "The Two Classes of Mankind." (See text of address in this issue.)

After the Address, the House gave Dr. Lieber a standing ovation.

INTRODUCTION OF OUT-OF-STATE GUESTS

Dr. Lieber introduced the following out-of-state guests: Dr. Eli Goodman, Chairman, Board of Trustees, Indiana State Medical Association, Charlestown, Indiana; Dr. Robert M. Leitch, President, Michigan State Medical Society, Battle Creek, Michigan; Dr. Jack Leckie, President, West Virginia State Medical Association, Huntington, West Virginia; and Dr. Charles J. Picard, President, State Medical Society of Wisconsin, Superior, Wisconsin.



INTRODUCTION OF GUESTS

Dr. Lieber introduced the following guests: Mr. Richard L. Sims, Columbus, representing the Ohio Hospital Association; Mrs. Marjorie Williams, Cincinnati, President, Cincinnati District, Ohio Nurses Association, representing the Ohio Nurses Association; Alford C. Diller, M.D., Convoy, President, Ohio Academy of Family Physicians; Mr. Irving S. Feuer, President, Ohio State Pharmaceutical Association; Mrs. Robert E. Krone, Cincinnati, President, Ohio State Medical Association Auxiliary; Mrs. William Myers, Circleville, President-Elect, Ohio State Medical Association Auxiliary; Ms. Nina LaBarbera, Youngstown, President-Elect, Ohio State Society of Medical Assistants.

INTRODUCTION OF AMSA REPRESENTATIVES

Dr. Lieber introduced the following representatives from the American Medical Student Association: Mr. Steven M. Skalina and Mr. Steven J. Czinn, representing Case Western Reserve University; Mr. Gregory J. Legree, The University of Cincinnati; and Mr. Pat Jonas and Mr. Mark Mahler, The Ohio State University College of Medicine.



(Proceedings continued on page 401)



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- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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House of Delegates' Proceedings

OSMA PAST PRESIDENTS INTRODUCED

The following Past Presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. Charles L. Hudson, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. George W. Petznick, Cleveland; Dr. Henry A. Crawford, Cleveland; Dr. Robert E. Howard, Cincinnati; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. Richard L. Fulton, Columbus; Dr. P. John Robeck, Cleveland; Dr. William R. Schultz, Wooster; Dr. Oscar W. Clarke, Gallipolis; and Dr. James L. Henry, Grove City.



INTRODUCTION OF AMA BOARD OF TRUSTEES MEMBER

Dr. Lieber then introduced Dr. John H. Budd, Cleveland, a member of the Board of Trustees of the American Medical Association, whom he described as a master statesman—master spokesman.

INTRODUCTION OF THE CHAIRMAN OF THE OHIO DELEGATION TO THE AMA

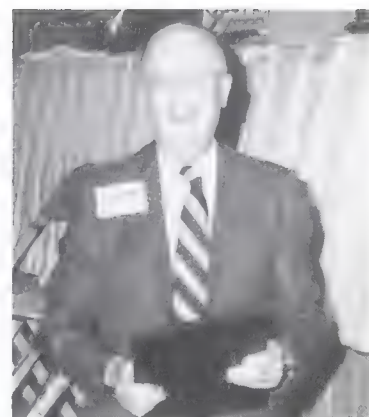
Dr. Lieber then introduced Dr. P. John Robeck, Cleveland, Chairman of the Ohio Delegation to the AMA, who made a brief announcement with regard to the John Budd for President-Elect of the AMA Campaign.

INTRODUCTION OF PAST MEMBERS OF THE OSMA COUNCIL

Dr. Lieber next introduced former members of the Council: Dr. Chester H. Allen, Portsmouth; Dr. Dwight L. Becker, Lima; Dr. Philip B. Hardymon, Columbus; Dr. Charles W. Hoyt, Cincinnati; Dr. J. P. McAfee, Portsmouth; Dr. James C. McLarnan, Mt. Vernon; Dr. Paul F. Orr, Perrysburg; and Dr. George J. Schroer, Ft. Loramie.

OSMA LEGAL COUNSEL INTRODUCED

Dr. Lieber introduced Mr. James E. Pohlman, Columbus, OSMA Legal Counsel.



REPORT OF AUXILIARY PRESIDENT

Mrs. Robert E. Krone, Cincinnati, President of the Ohio State Medical Association Auxiliary, was escorted to the podium by Dr. Frank H. Mayfield, to address the House of Delegates on various activities of the Auxiliary during her term of office. (See text of address in this issue.)

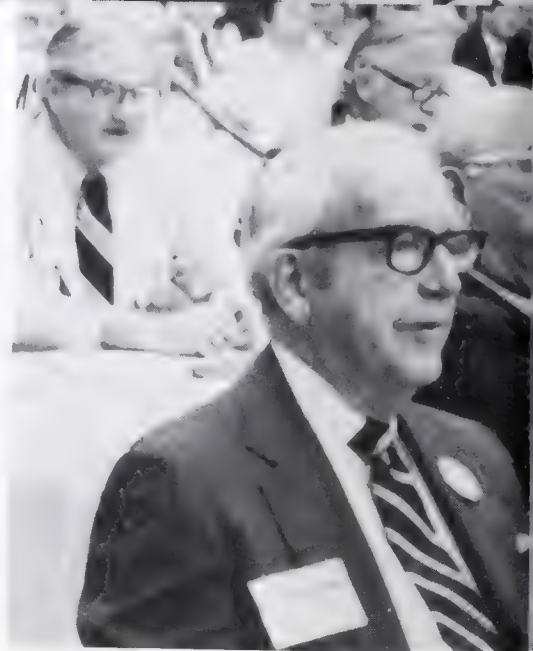
AMA-ERF CHECKS PRESENTED

Dr. Philip B. Hardymon, Columbus, Chairman of Ohio's Committee for the American Medical Association's Education and Research Foundation, made the presentation of the AMA-ERF check as follows: Dr. Frederick T. Suppes, Faculty, Case Western Reserve School of Medicine, Cleveland (check for \$13,038.27); Dr. J. Hutchison Williams, Faculty, The Ohio State University College of Medicine, Columbus (check for \$16,479.74); Dr. B. Leslie Huffman, Jr., representing the Medical College of Ohio at Toledo (check for \$5,878.65); Mrs. Robert E. Krone, representing the University of Cincinnati College of Medicine (check for \$18,492.37); Dr. Stanley W. Olson, Provost, Northeastern Ohio Universities College of Medicine, Kent (check for \$3,581.84); and Dr. John R. Beljan, Dean, Wright State University School of Medicine, Dayton (check for \$5,271.63).

Dr. Hardymon pointed out that this project was so successful due to the help of the Ohio State Medical Association Auxiliary, and he asked Mrs. Krone and other Auxiliary members present to stand and accept the applause of the House of Delegates.



(Annual Meeting continued page 402)





House of Delegates' Proceedings

PLAQUES AND CERTIFICATES OF APPRECIATION

A certificate of appreciation was presented to Dr. Henry A. Crawford, Cleveland, for his service as a member of the Standing Committee on Judicial and Professional Relations.

The following retiring chairmen of special committees were honored: Dr. Robert G. Thomas, Elyria, Committee on Auditing and Appropriations; Dr. Robert E. Rinderknecht, Dover, Council Fee Review Committee; Dr. Clarence L. Huggins, Cleveland, Committee on Health Care of the Poor; Dr. Robert M. Craig, Dayton, Committee on Hospital Relations; Dr. George N. Bates, Toledo, Medical Advances Institute Committee; Dr. James L. Henry, Grove City, Ohio Medical Indemnity Committee; and Dr. Stephen P. Hogg, Cincinnati, Auxiliary Advisory Committee.

Dr. William R. Schultz, Wooster, was presented a certificate of appreciation for his service to the Association as a retiring member of the OSMA Delegation to the AMA.

Dr. James L. Henry, Grove City, received a plaque in appreciation of his service to the Association as retiring member of the Council.

Dr. Lieber then presented certificates to the Life Active Members: Dr. William Henrik Kose, Findlay, and Dr. H. William Porterfield, Columbus.



PRESENTATION OF SPECIAL AWARD

Dr. Lieber then announced that a special award was being presented to a 25-year OSMA staff member. Mrs. Ada Kelly was escorted to the podium by Dr. Oscar W. Clarke and accepted the award.

REFERENCE COMMITTEES APPOINTED

The following House of Delegates Reference Committees were appointed by the President:

Credentials of Delegates—Andrew J. Weiss, Chairman, Hamilton County; George J. Schroer, Shelby County; B. Leslie Huffman, Jr., Lucas County; Lawrence J.

McCormack, Cuyahoga County; and Edward J. Davis, Stark County.

President's Address—William A. White, Jr., Chairman, Stark County; Harry K. Hines, Hamilton County; and Vincent T. LaMaida, Cuyahoga County.

Tellers and Judges of Election—Richard L. Fulton, Chairman, Franklin County; Stewart B. Dunsker, Hamilton County; Carlos O. Andarsio, Clark County; Nicholas G. DePiero, Cuyahoga County; and Carl E. Spragg, Muskingum County.

Resolutions Committee No. 1—A. Burton Payne, Chairman, Lawrence County; Eugene J. Burns, Hamilton County; A. Robert Davies, Miami County; David A. Barr, Allen County; John A. Devany, Lucas County; P. John Robeck, Cuyahoga County; Joseph Sudimack, Jr., Trumbull County; Philip T. Doughten, Tuscarawas County; John F. Kroner, Athens County; Thomas P. Price, Jr., Gallia County; Homer A. Anderson, Franklin County; Luther W. High, Holmes County; and Warren P. Kilway, Summit County.

Resolutions Committee No. 2—Frederick T. Suppes, Chairman, Cuyahoga County; James M. Smith, Butler County; Ernest H. Winterhoff, Clark County; Robert Elliott, Hardin County; John F. Bodie, Ottawa County; Theodore J. Castele, Cuyahoga County; Raymond J. McMahon, Jr., Stark County; Robert R. Johnson, Coshocton County; Robert A. Ringer, Guernsey County; John W. Zimmerly, Jackson County; Joseph A. Bonta, Franklin County; A. Burney Huff, Wayne County; and Fred F. Somma, Summit County.

Resolutions Committee No. 3—Edward E. Grable, Chairman, Stark County; Glenn B. Doan, Highland County; John H. Taylor, Montgomery County; Walter A. Daniel, Seneca County; Peter A. Overstreet, Lucas County; Wesley J. Pignolet, Lake County; William Banfield, Columbiana County; Donald R. Piatt, Monroe County; Walter B. Devine, Muskingum County; Chester H. Allen, Scioto County; David J. Hickson, Morrow County; S. Baird Pfahl, Jr., Erie County; and F. Michael Sheehan, Portage County.

ELECTION OF COMMITTEE ON NOMINATIONS

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: **First District**—Charles D. Feuss, Jr., Hamilton County; **Second District**—Isador Miller, Champaign County; **Third District**—Joseph M. Oppenheim, Allen County; **Fourth District**—Roland A. Gandy, Jr., Lucas County; **Fifth District**—Edward G. Kilroy, Cuyahoga County; **Sixth District**—James J. Anderson, Mahoning County; **Seventh District**—Felipe V. Lavapies, Belmont County; **Eighth District**—Gregory Krivchenia, Washington County; **Ninth District**—Lethia Starr, Hocking County; **Tenth District**—John N. Meagher, Franklin County; **Eleventh District**—Harold F. Mills, Richland County; **Twelfth District**—Roy E. Bugay, Summit County.

Dr. Lieber then announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the Third District, Dr. Joseph M. Oppenheim, Allen County.

INTRODUCTION OF RESOLUTIONS

Dr. Lieber then called for the introduction of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to the delegates in advance of the meeting could be introduced by reading of the title only. Forty-seven resolutions were introduced and were referred to the resolutions committees.

REPORT OF THE COMMITTEE ON EMERGENCY RESOLUTIONS

The Committee on Emergency Resolutions, consisting of the chairmen of the three resolutions committees, met to consider two emergency resolutions, one submitted by the Academy of Medicine of Cincinnati, entitled "Amendment of Informed Consent Form (Amended Substitute House Bill 682)," and the other submitted by W. W. Tuckerman, M.D., Cleveland, entitled "Council Implemented Malpractice Action Program." It was the opinion of the Committee that only one resolution qualified as a justified Emergency Resolution, the resolution entitled "Council Implemented Malpractice Action Program." This resolution was assigned by the Committee to Resolutions Committee No. 1 and was numbered "Resolution No. 48-76."

By official action, the report was adopted.

HOUSE RECESSED

The House then recessed until the final session, 3:30 PM, Wednesday, May 12.



Minutes of the Final Session

The final business session of the House of Delegates convened at 3:30 PM, Wednesday, May 12, at the Cincinnati Exposition Center, Cincinnati.

Dr. Lieber introduced David A. Hull, M.D., President, Kentucky Medical Association, Lexington, Kentucky.

Dr. Lieber next introduced Dr. Oscar W. Clarke, Vice-Chairman of the Ohio Delegation to the AMA, who said a few words about the Budd Campaign.

REPORT OF CREDENTIALS COMMITTEE

Dr. Andrew J. Weiss, Cincinnati, Chairman of the Committee on Credentials, reported that out of 176 delegates eligible to vote, 168 were seated.

PRESENTATION OF ART SHOW AWARDS

Dr. Lieber made the following announcement on the art show winners:

Photo Art: First Place—Dorothy Hoak, Troy (wife of Dr. Carl Hoak); Second Place—Richard Buchanan, M.D., Wilmington; Third Place—Lois Dorfman, Toledo (wife of Dr. Simon Dorfman).

Sculpture: First Place—Charlotte Baron, Cincinnati (wife of Dr. Charles Baron); Second Place—Lois Dorfman, Toledo (wife of Dr. Simon Dorfman); Third Place—Louise Hines, Minerva (wife of Dr. Robert Hines).

Water Color: First Place—Ritha M. Spitz, Cincinnati (wife of Dr. Louis Spitz); Second Place—Julia Wiese, Cincinnati (wife of Dr. Frederick Wiese); Third Place—Sanford Courter, M.D., Cincinnati.

Oil: First Place—Stephen Vance, M.D., Cincinnati; Second Place—Richard Glins, M.D., Hamilton; Third Place—Victor Laughlin, M.D., Cleveland.

Crafts: First Place—Lois Dorfman, Toledo (wife of Dr. Simon Dorfman); Second Place—Joseph Warkany, M.D., Cincinnati; Third Place—Jeffrey Parker, M.D., Cincinnati.

Dr. Lieber then called the Art Show Chairman, Dr. Harry H. Fox, Cincinnati, to come forward and accept

(Proceedings continued page 406)

House of Delegates' Proceedings

an award for his outstanding contribution in making the Art Show a success. Dr. Fox accepted the award with thanks and told briefly about the show.



ELECTION OF PRESIDENT-ELECT

Dr. Lieber called for nominations for the office of President-Elect. Dr. Frank H. Mayfield, Cincinnati, placed in nomination Dr. Stephen P. Hogg, Cincinnati, Hamilton County, Councilor of the First District. The nomination was seconded by Dr. James G. Tye, Dayton. Dr. Jack E. Tetirick, Columbus, placed in nomination Dr. James C. McLarnan, Mt. Vernon, Knox County, a former Councilor of the Tenth District. The nomination was seconded by Dr. David J. Hickson, Mt. Gilead. Dr. Richard E. Hartle, Lancaster, placed in nomination Dr. William M. Wells, Newark, Licking County, Secretary-Treasurer. The nomination was seconded by Dr. P. John Robeck, Cleveland. There were no other nominations, and Dr. Wells was elected on the second ballot.

REPORT OF NOMINATING COMMITTEE

Dr. Joseph M. Oppenheim, Delegate, Allen County, Chairman of the Committee on Nominations, presented the report of the Nominating Committee, as follows:

First District: As Councilor of the First District to succeed Dr. Stephen P. Hogg, Cincinnati, the Committee placed in nomination Dr. Stewart B. Dunsker, Cincinnati. The nomination being duly seconded and there being no

further nominations from the floor, by official action the nominations were closed and Dr. Dunsker was declared elected Councilor of the First District for a term of two years, 1976-1977 and 1977-1978.

Third District: As Councilor of the Third District to succeed Dr. John C. Smithson, Findlay, the Committee placed in nomination Dr. Alford C. Diller, Convoy. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Diller was declared elected Councilor of the Third District for a term of two years, 1976-1977 and 1977-1978.

Fifth District: As Councilor of the Fifth District to succeed himself, the Committee placed in nomination Dr. John J. Gaughan, Cleveland. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Gaughan was declared reelected Councilor of the Fifth District for a term of two years, 1976-1977 and 1977-1978.



Seventh District: As Councilor of the Seventh District to succeed himself, the Committee placed in nomination Dr. Robert E. Rinderknecht, Dover. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Rinderknecht was declared reelected Councilor of the Seventh District for a term of two years, 1976-1977 and 1977-1978.

Ninth District: As Councilor of the Ninth District to succeed himself, the Committee placed in nomination Dr. Thomas W. Morgan, Gallipolis. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Morgan was declared reelected Councilor of the Ninth District for a term of two years, 1976-1977 and 1977-1978.

Eleventh District: As Councilor of the Eleventh District to succeed Dr. Robert G. Thomas, Elyria, the Committee placed in nomination Dr. S. Baird Pfahl, Jr., Sandusky. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Pfahl was declared elected Councilor of the Eleventh District for a term of two years, 1976-1977 and 1977-1978.





Secretary-Treasurer: For Secretary-Treasurer, the Committee placed in nomination Dr. Robert G. Thomas, Elyria, Eleventh District Councilor. The nomination was seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Thomas was declared elected Secretary-Treasurer for a term of three years, 1976-1979.

AMA Delegates: Dr. Oppenheim then presented the nominees for the office of Delegate to the American Medical Association for a term of two years beginning January 1, 1977: Drs. Jerry L. Hammon, West Milton; Richard L. Meiling, Columbus; H. William Porterfield, Columbus; Jack Schreiber, Canfield; and Robert N. Smith, Toledo. The nominations were duly seconded, and there were no further nominations from the floor. A secret ballot was taken, and Drs. Hammon, Porterfield, Schreiber and Smith were declared elected.

AMA Alternate Delegates: For Alternate Delegates to the American Medical Association for a term of two years beginning January 1, 1977, the Nominating Committee placed in nomination the names of Drs. John E. Albers, Cincinnati; Dwight L. Becker, Lima; B. Leslie Huffman, Jr., Maumee; and Robert G. Thomas, Elyria. The nominations were duly seconded, and there were no further nominations from the floor. Drs. Albers, Becker, Huffman, and Thomas were declared reelected.

For the two one-year terms to fill the vacancies created by Drs. Hammon and Schreiber being elected Delegates, Drs. Theodore J. Castele, Cleveland, and William J. Schrimpf, Cincinnati, were nominated. The nominations were duly seconded, and there were no further nominations from the floor. Drs. Castele and Schrimpf were unanimously elected Alternate Delegates for a term beginning January 1, 1977, and ending December 31, 1977.

A recommendation of the Nominating Committee that the incumbents be surveyed and that information be presented one day prior to the meeting was adopted.

The report of the Nominating Committee was approved.

Dr. Lieber then recognized Dr. C. Edward Pichette, Youngstown, Sixth District Councilor, who gave the following tribute to Dr. Robert E. Tschantz, former Delegate to the AMA:

It seems appropriate at this time to request of this House a standing ovation in honor of a man who has given 30 years of service to this organization. I would move that we send Bob Tschantz a message that we miss him, that we hope he does well, and that he and his wife enjoy many years of loving and lovely retirement. We thank him and his wife for his untiring service and loyalty to the medical profession.

COMMITTEE ON PRESIDENT'S ADDRESS

Dr. Lieber then called for the report of the Reference Committee on President's Address (see text of address in this issue), which was presented by Dr. William A. White, Jr., Stark County, Chairman of the Committee. The report read as follows:

The Committee congratulates President Lieber on his presidential address "The Two Classes of Mankind."

The address was comprehensive, well researched, and moved rapidly.

It was emphasized that not only medicine but our entire nation finds itself in fast-moving, troubled times. Our problems are to be solved by a program of unity, involvement and action which can be achieved only by grass-roots participation of our members. This participation is possible only by the preservation of the AMA federation concept.

Our involvement must increase in tempo and our commitment unswerving to keep up "with the deluge of state laws, federal laws and administrative laws that rain down on us daily and constantly. It is unthinkable that a doctor abandon his profession and his patients by pleading that he is too busy with his practice to become involved."

In keeping with the modern concept of audiovisual presentation, Doctor Lieber made excellent use of the AMA's "Jogging Film" to illustrate the fact that we must run faster and faster just to stand still in our fast-moving world.

Dr. Lieber clearly pointed out that he was reporting on his stewardship as President of the Ohio State Medical Association, not presenting an exposition of his philosophy. He reported the actions of the Council and the House of Delegates coordinated with the policies of the AMA to achieve a unified approach to the problems induced by the proliferation of federal and state laws.

He provided a penetrating insight into a major cause of our dilemma with an apt quote from the Roman historian Tacitus who was describing America today when he wrote, in the First Century, "When the state is most corrupt, then the laws are most multiplied."

Dr. Lieber analyzed the problems and the actions taken in the last year concerning passage of legislation sought by OSMA by the Ohio General Assembly, organization of Ohio's Joint Underwriting Association, the Ohio Attorney General's suit against the Ohio Medical Indemnity Corporation and the



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OSMA, the National Health Resources and Development Act (Public Law 93-641), Federalized health care, the medical manpower problem and the continuing medical education program of the OSMA.

He stressed the special letter of April 21, 1976, soliciting from each OSMA member a \$100 voluntary contribution to finance a vital five-point program which the Task Force on Professional Liability has developed.

Dr. Lieber summarized recent developments and problems created by the Goldfarb Decision of the United States Supreme Court, a "landmark" case which subjects all the professions to the antitrust laws.

He pointed out that Dr. James Sammons, Vice-President of the AMA, has publicly described the National Health Resources Act of 1974 as "The single, most potentially destructive piece of medical legislation ever enacted by Congress," emphasizing that this legislation establishes regions reporting directly to the Secretary of Health, Education, and Welfare thus effectively by-passing the state governments as well as all organized medicine except in an advisory capacity.

The renewed, vigorous and effective advocacy role of the AMA in speaking for all physicians in their desire to continue and expand the high quality of medical care for all Americans was lauded. Dr. Lieber urged our dedicated support for the election of our own Dr. John Budd to the office of President-Elect of the AMA.

Dr. Lieber vividly and forcefully exposed the hoax of National Health Insurance by quoting telling statistics from a study by the Department of Health, Education, and Welfare proving that American medical practice has resulted in Americans being healthier, living longer, and living better than at any time in the past. He sagely remarked, "The greatest effect on health improvement of Americans would come and should come through better living habits including saner eating, drinking, smoking, and exercise habits. This could do more for Americans' health than all the legislation in the world."

Organized medicine was recognized for its strenuous and effective efforts in fostering a 70 percent increase in enrollment in medical schools and the establishment of 29 new medical schools in the last 10 years with 11 more in the planning and organization stage. The tremendous swing toward primary care on the part of medical school graduates was noted—58 percent in the last year.

Dr. Lieber stressed the desirability of carefully considering the implications of the dangers as well as the benefits which can accrue to Americans by implementation of the proposed swine influenza immunization program.

The conclusion of the presidential address, however, places it above the class of the entirely excellent presidential addresses that we have come to expect at our Annual Meetings over the years. Dr. Lieber, quoting from Rudyard Kipling and Robert Louis Stevenson, forcefully and unmistakably identified the unique relationship of the medical profession to society. This, the doctor-patient relationship, must be zealously guarded and maintained for the benefit of our patients.



In the light of his cogent recognition and his firm strides to solve our current problems, we congratulate Dr. Lieber on his address and on his year-long efforts as OSMA President. We express our best wishes to his successor, knowing that his obstacles will be formidable and his challenges severe, but confident that he will take every pain and make every effort to preserve "The Two Classes Of Mankind."

Respectfully submitted, Committee on the President's Address: Harry K. Hines, Hamilton County; Vincent T. LaMaida, Cuyahoga County; William A. White, Jr., Stark County Chairman.

On a motion made and seconded, the House of Delegates, by official action, approved the report of the Reference Committee on President's Address.



REPORT OF RESOLUTIONS COMMITTEE NO. 1

Dr. A. Burton Payne, Lawrence County, reported for Resolutions Committee No. 1, of which he was Chairman. The report read as follows:

Resolutions Committee No. 1 met in open session on Monday, May 10, 1976, and heard testimony relating to the 17 resolutions which were assigned to this Committee. The Committee hearings were well attended and received a very adequate amount of knowledgeable and sincere testimony.

The Committee decided to consider all resolutions in 5 basic groups dealing with various aspects of professional liability.

Resolutions Nos. 6-76, 12-76, 29-76, 44-76

The first group of resolutions discussed dealt primarily with lawsuits. After hearing testimony from a number of physicians, the Committee decided to offer the following substitute resolution.

Amended Substitute Resolution No. 6-76 Legal Redress

WHEREAS, A substantial number of medical malpractice suits are filed in Ohio each year; and
WHEREAS, The rising cost of professional liability premiums have contributed to the increased cost of medical care, and have encouraged defensive medicine; and
WHEREAS, To date there has been no effective deterrent to the large number of mischievous and frivolous professional liability claims being filed against sincere, honest and competent physicians, THEREFORE BE IT
RESOLVED, That the OSMA Council take positive action to encourage, sponsor, and endorse legal action to permit a physician to seek redress in the event that the physician was named as a defendant in a lawsuit when an ordinary review of pertinent medical records and other evidence would have shown that the defendant was not a party to the proximate cause of the incident that is the subject of the dispute; and
BE IT FURTHER

RESOLVED, The Ohio State Medical Association Council should encourage and support action to establish the principle that if the defendant is found not liable in a malpractice action, the payment of all court costs and attorney fees of both plaintiff and defendant will be the responsibility of the plaintiff **AND THE PLAINTIFF'S ATTORNEY**; and **BE IT FURTHER**

RESOLVED, That the Ohio State Medical Association Council should actively develop and sponsor legislation and procedural rules which would have the following provision: In any action for damages for personal injury or death, whether based on tort or contract law, a counterclaim for damages for abuse of process in filing such action may be filed and litigated in the same action.

Mr. President, I move the adoption of substitute Resolution No. 6-76.

By official action, the House **voted to amend Substitute Resolution No. 6-76 as indicated by the additions set forth in capital letters, then adopted it.**

**Resolution No. 8-76
Provider Owned Insurance Company**

Next the Committee discussed Resolution No. 8-76 and voted to amend the resolution as follows:

Amended Resolution No. 8-76

WHEREAS, The establishment of a JUA has not encouraged private insurance carriers to remain in the medical professional liability insurance market; and

WHEREAS, Two major medical professional liability insurance carriers have refused to renew the policies of physicians in this State; and

WHEREAS, The American Medical Association has formed a reinsurance company that will guarantee a reinsurance market for captive insurance companies in this and other states; and

WHEREAS, The Ohio State Medical Association Council has already established a task force to consider the formation of a captive company; **THEREFORE BE IT**

RESOLVED, That the Ohio State Medical Association Council shall continue to research the feasibility of forming a health care provider owned insurance company and shall report their recommendations to the House of Delegates of the OSMA as soon as possible.

Mr. President, I move the adoption of Amended Resolution No. 8-76.

By official action, the House **voted to adopt Amended Resolution No. 8-76.**

Resolutions Nos. 21-76, 31-76, 39-76

The next group of resolutions to be discussed dealt with professional liability data. The Committee felt that there was a similarity of intent in these resolutions and, therefore, would like to present the following substitute resolution:

**Substitute Resolution No. 21-76
Professional Liability Data**

WHEREAS, Statistics should be gathered to demonstrate the cost of medical professional liability insurance and its impact on the cost of health care to the citizens of this State and to study pertinent data on suits alleging medical malpractice; and

WHEREAS, No factual data have been published by the Ohio



Department of Insurance to substantiate insurance rate increases; and

WHEREAS, Increased costs for insurance are reflected in increased costs for medical services or potential curtailment of medical services; and

WHEREAS, The Ohio State Medical Association Council has followed the directive of the 1975 OSMA House of Delegates in Substitute Resolution No. 2-75, Professional Liability, and has taken appropriate action to form the Task Force on Professional Liability; **THEREFORE BE IT**

RESOLVED, That the Ohio State Medical Association Council be commended for their action and instructed to continue their efforts in this direction.

Mr. President, I move the adoption of Substitute Resolution No. 21-76.

By official action, the House **voted to adopt Substitute Resolution No. 21-76.**

**Resolution No. 9-76
Retired Physician Exempt From
Stabilization Reserve Fund**

The next resolution to be discussed by the Committee was Resolution No. 9-76. After considerable discussion and consultation with the OSMA Legal Counsel and staff, the Committee proposes the following amended resolution:

Amended Resolution No. 9-76

WHEREAS, The 111th General Assembly of Ohio has passed Amended Substitute House Bill 682; and

WHEREAS, Amended Substitute House Bill 682 provides for the establishment of a Stabilization Reserve Fund to be funded by assessments on members and nonmembers of the Joint Underwriting Association; and

WHEREAS, The language of Section 3929.74 of Amended Substitute House Bill 682 requires that an assessment for the Stabilization Reserve Fund be paid by all members of the Joint Underwriting Association including retired and deceased physicians who purchase the reporting endorsement; and

WHEREAS, This requirement works a definite hardship upon such retired physicians; **THEREFORE BE IT**

RESOLVED, That the Ohio State Medical Association Council shall sponsor legislative amendments that will exempt from the assessment to the Stabilization Reserve Fund physicians who are retired or deceased.

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Mr. President, I move the adoption of this Amended Resolution No. 9-76.

By official action, the House voted to adopt Amended Resolution No. 9-76.

Resolution No. 10-76 Automatic Issuance of Reporting Endorsement by JUA

The Committee next discussed Resolution No. 10-76 and after due consideration unanimously recommended the adoption of the resolution and, Mr. President, I so move.

The resolution reads as follows:

Resolution No. 10-76 Automatic Issuance of Reporting Endorsement by JUA

WHEREAS, Amended Substitute House Bill 682 provided for the establishment of a Joint Underwriting Association; and
WHEREAS, The Joint Underwriting Association known as the Ohio Medical Professional Liability Insurance Underwriting Association, is by law required to issue a claims-made policy with a guaranteed right to purchase a reporting endorsement providing insurance protection for claims reported after the policy period; and

WHEREAS, The assets of a retired physician or the estate of a deceased physician may be placed in jeopardy if the physician or the estate of a physician insured by the JUA neglects to purchase the reporting endorsement; THEREFORE BE IT

RESOLVED, That remedial legislation be introduced to require the Ohio Medical Professional Liability Underwriting Association to automatically issue the reporting endorsement to the physician or the estate of the physician upon termination of the primary or excess policy without requiring affirmative action by the physician or his estate, and that such reporting endorsement shall be in force unless the physician or his estate refuses the coverage in writing, or refuses to pay the premium within the required grace period.

By official action, the House voted to adopt Resolution No. 10-76.

Resolution No. 17-76 Policyholder Consent to Settlements

The next resolution to be considered was Resolution No. 17-76 which dealt with policyholder consent to settlements. After a reasonable amount of discussion the Committee voted to recommend the following amended resolution:

Amended Resolution No. 17-76

WHEREAS, Amended Substitute House Bill 682 has, by statute, established a Joint Underwriting Association known as the Ohio Medical Professional Liability Underwriting Association; and

WHEREAS, Policies issued by the Association do not contractually require that the Association obtain from the policyholder/defendant consent to settle a claim or suit; and

WHEREAS, The willingness of professional liability insurance carriers to settle many cases where the negligence of the provider is questionable or nonexistent has contributed to the ever-growing crisis in medical malpractice, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association Council seek legislative amendments to require that the Ohio Medical Professional Liability Insurance Underwriting Association obtain consent from either the policyholder/defendant, or a medical review panel of his peers before settling a claim out of court.

Mr. President, I move the adoption of this amended resolution.

By official action, the House voted to adopt Amended Resolution No. 17-76.

Resolution No. 18-76 JUA to Offer Occurrence Contracts

Resolution No. 18-76, entitled "JUA to Offer Occurrence Contracts," was the next resolution to be considered. The Committee voted to recommend the following amended resolution:

Amended Resolution No. 18-76

WHEREAS, Amended Substitute House Bill 682 provides for the creation of a Joint Underwriting Association; and

WHEREAS, Section 3929.73(B) of the Ohio Revised Code requires that the insurance contracts issued by the Association shall be written on a claims-made basis and that the policyholder shall have the guaranteed right to purchase coverage for claims reported after the policy period, which converts a claims-made policy to an occurrence policy; and

WHEREAS, The pricing formula for complete JUA coverage shows that the aggregate payments will be equal to the aggregate cost for an occurrence policy during the same period; and

WHEREAS, It is desirable for a physician to pay the full cost for his professional liability insurance during a period of economic productivity rather than to require payments when income is no longer being earned, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association Council shall prepare and sponsor legislation to require that the Ohio Medical Professional Liability Insurance Underwriting Association offer an occurrence contract to its policyholder.

Mr. President, I move the adoption of Amended Resolution No. 18-76.

By official action, the House voted to adopt Amended Resolution No. 18-76.

Resolution No. 19-76 Clarification of Statute of Limitations

As the Committee discussed Resolution No. 19-76, there was a general consensus of opinion that the present law was satisfactory and that this resolution was ambiguous. Therefore, we recommend that Resolution No. 19-76 be not adopted and, Mr. President, I so move.

By official action, the House voted to reject Resolution No. 19-76.

**Resolution No. 20-76
Impartial Arbitration**

The Committee next discussed Resolution No. 20-76, Impartial Arbitration. After a considerable amount of discussion the Committee decided to recommend the following amended resolution:

Amended Resolution No. 20-76

WHEREAS, Section 2711.21 of the Ohio Revised Code requires that all medical claims shall be submitted to an arbitration board; and
WHEREAS, The statute permits the plaintiff and defendant to designate an arbitrator and also permits the court to designate the third arbitrator who shall be chairman of the board; and
WHEREAS, The right of the plaintiff and defendant to designate an arbitrator implies that these two arbitrators may cancel out each other which would in reality mean arbitration by one person; THEREFORE BE IT
RESOLVED, That the Ohio State Medical Association Council shall continue to study the method by which arbitrators are selected and devise a method of selection to assure that all members of the arbitration board shall be competent, disinterested parties.

Mr. President, I move the adoption of this amended resolution.

By official action, the House voted to adopt Amended Resolution No. 20-76.

**Resolution No. 30-76
Medical Liability Insurance Premiums
Related to Exposure**

The Committee discussed Resolution No. 30-76 and felt that only two minor adjustments need be made; therefore, the Committee recommends adoption of the following Amended Resolution No. 30-76:

Amended Resolution No. 30-76

WHEREAS, The present cost of medical liability insurance even under the Joint Underwriting Authority is high; and
WHEREAS, This high cost might interfere with young doctors entering into private practice; and
WHEREAS, This high cost might cause older physicians to retire instead of remaining in practice with reduced patient load; and
WHEREAS, These physicians are essential to the further development and maintenance of private practice in this state; and
WHEREAS, These groups of physicians have limited exposure to liability because of reduced patient load; THEREFORE BE IT
RESOLVED, That the Ohio State Medical Association Council petition the Joint Underwriting Authority for development of a program of sliding scaled reduced premiums for beginning, retiring, and part-time practitioners of medicine.

Mr. President, I move the adoption of Amended Resolution No. 30-76.

By official action, the House voted to adopt Amended Resolution No. 30-76.

**Resolution No. 45-76
Special Assessment for Proposed Countersuits
and
Emergency Resolution 48-76
Council Implemented Malpractice Action Program**

Finally, the last two resolutions considered by this Committee were Resolution No. 45-76 and Emergency Resolution 48-76. The Committee felt that these resolutions were addressed to very important aspects of OSMA Task Force assessments and countersuit financing. After much discussion, it was decided to present the following substitute resolution:

**Substitute Resolution No. 45-76
Special Assessments**

WHEREAS, A substantial number of medical malpractice suits are filed in Ohio each year; and
WHEREAS, The filing of these frivolous and malicious suits constitute a constant harassment to physicians; and
WHEREAS, The Council of the Ohio State Medical Association, through its Task Force on Professional Liability, has seen fit to launch a major investigative fact-finding program to hopefully help solve the malpractice problem in the State of Ohio; THEREFORE BE IT
RESOLVED, That the Ohio State Medical Association Council be directed to establish a mechanism to advise, assist and support Ohio physicians regarding countersuits against such party or parties who, in the opinion of OSMA Legal Counsel, have initiated baseless and frivolous professional liability proceedings; and BE IT FURTHER
RESOLVED, That the OSMA Council be commended for their work to date and be reminded of their responsibilities regarding timely reports to the OSMA membership; and BE IT FURTHER
RESOLVED, That the Ohio State Medical Association Task Force on Professional Liability be funded by voluntary solicitation of the OSMA membership.

Mr. President, the Committee recommends adoption of Substitute Resolution No. 45-76, and I so move.

By official action, the House voted to adopt Substitute Resolution No. 45-76.



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Mr. President, that concludes the report of Resolutions Committee No. 1. I would like to take this opportunity to thank all members who testified before the Committee in open session. I would also like to thank the members of this Committee for their diligent work, as well as Vickey McVay, OSMA staff member, and James E. Pohlman, OSMA Legal Counsel.

Mr. President, I move adoption of the report of Resolutions Committee No. 1.

Respectfully submitted, Resolutions Committee No. 1: Eugene J. Burns, Hamilton County; A. Robert Davies, Miami County; David A. Barr, Allen County; John A. Devany, Lucas County; P. John Robeck, Cuyahoga County; Joseph Sudimack, Jr., Trumbull County; Philip T. Doughten, Tuscarawas County; John F. Kroner, Athens County; Thomas P. Price, Jr., Gallia County; Homer A. Anderson, Franklin County; Luther W. High, Holmes County; Warren P. Kilway, Summit County; and A. Burton Payne, Lawrence County, Chairman.

The report of Resolutions Committee No. 1, as a whole, as amended, was approved by the House.



REPORT OF RESOLUTIONS COMMITTEE NO. 2

Dr. Frederick T. Suppes, Cuyahoga County, reported for Resolutions Committee No. 2, of which he was Chairman. The report read as follows:

I am pleased to submit the Report of Resolutions Committee No. 2, which contained sixteen resolutions for action of the Delegates of this organization.

The first resolution is Resolution 1-76, regarding a Parliamentarian. The resolution has been amended as follows:



Amended Resolution 1-76 Parliamentarian

WHEREAS, the business of the House of Delegates of the Ohio State Medical Association should proceed with dispatch and proper order, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association provide an accomplished and competent parliamentarian to insure orderly procedure for each session of the House of Delegates.

Mr. President, I move the adoption of Amended Resolution No. 1-76.

By official action, the House voted to adopt Amended Resolution No. 1-76.

Resolution No. 35-76 Citizenship Requirements

The Committee considered Resolution No. 2-76 and Resolution No. 35-76 together.

The Resolutions Committee was most appreciative of the presentation of the problem of those practicing physicians who were awaiting fulfillment of their eligibility requirements for citizenship. This was well demonstrated in graphic form for the audience and Resolutions Committee.

The Committee believes that Resolution No. 35-76 adequately and fairly remedies the problem and, therefore, Mr. President, the Committee moves its adoption.

The resolution reads as follows:

Resolution No. 35-76 Citizenship Requirements

WHEREAS, Section 3 and Section 6 of Chapter I (Membership) of the By-Laws of the Ohio State Medical Association state that, to be eligible for membership in O.S.M.A., a non citizen must —

1. Live in the United States for a period of one year.
2. Must file in an appropriate court of record a declaration of intent to become a citizen.
3. Must wait three years after filing his declaration of intent before he can apply for membership in a component society.
4. Must exercise his intent to become a citizen within six years after filing his declaration of intent or else his membership in the component society will be cancelled; and,

WHEREAS, The Ohio State Medical Board will now issue a license to an applicant if one of the following is submitted:

1. Proof of citizenship.
2. Declaration of intent (official document of the court).
3. Alien registration receipt record (official document — U. S. Immigration Service).
4. Petition for Permanent Immigration Status (official document — U. S. Immigration Service); and

WHEREAS, Membership eligibility for the OSMA and the component county medical societies exceeds licensure requirements of the Ohio State Medical Board and thereby grants membership on citizenship status arbitrarily;

WHEREAS, It is desirable for all licensed physicians in Ohio to be eligible for membership to the O.S.M.A. and the component county medical societies; THEREFORE BE IT

RESOLVED, That the O.S.M.A. By-Laws be amended as follows: Chapter I Section 3; Delete paragraph (a); Paragraph (b) then becomes (a); and paragraph (c) becomes (b). Delete Section 6; Section 7 becomes 6 and 8 becomes 7.

By official action, the House voted to adopt Resolution No. 35-76.



**Resolution No. 3-76
Adding Faculty to Membership Category**

Mr. President, the Resolutions Committee heard testimony regarding this resolution submitted by the Ohio State Medical Association's Council.

There was not strong testimony to support the need for this new category. The Committee recommends that Resolution No. 3-76 **not** be adopted, and Mr. President, I so move.

By official action, the House voted to reject Resolution No. 3-76.

**Resolution No. 7-76
Confidentiality**

The Committee next heard testimony on the resolution and reviewed similar resolutions passed by this body in recent years, namely, Amended Resolution No. 25-73 and Resolutions No. 8-75 and 18-75. Reference was also made to action taken by Council regarding confidentiality in the years 1971 and 1972.

The Committee reviewed the action of the AMA Annual Meeting in 1975 regarding Item K, Confidentiality of Medical Information; Model State Legislation and the nine points outlining protection of confidentiality.

It is felt that the resolution is consistent with past OSMA and AMA activities in this area but should be amended as follows:

Amended Resolution No. 7-76

WHEREAS, Section 9 of the Principles of Medical Ethics states, "a physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community"; and

WHEREAS, Insurance companies, repositories of considerable confidential medical information, are not bound by the rigid ethical standards subscribed to by physicians; and

WHEREAS, Confidential medical information obtained by insurance companies and reported to an individual's employer may cause an individual to suffer humiliation and mental anguish; **THEREFORE BE IT**

RESOLVED, That the OSMA Council and Legal Counsel develop guidelines acceptable to insurance companies and physicians, that will define the right to request and the obligation to provide medical information with reference to the service or procedure for which the claim is made.

Mr. President, I move the adoption of Substitute Resolution No. 7-76.

By official action, the House voted to adopt Substitute Resolution No. 7-76.

**Resolution No. 15-76
OSMA Position on Public Law 93-641**

Testimony was provided to the Resolutions Committee regarding the Ohio State Medical Association support to the American Medical Association's policy regarding "National Health Planning and Resource Development Act of 1974." (The H.S.A. — 93-641.)

The OSMA policy statement was made on March 13, 1976, (and was included in the delegate packet) and, although it appears as though the charge of this resolution has been completed, it is the recommendation of this Committee that Resolution No. 15-76 be adopted by this House of Delegates for emphasis, and, Mr. President, I so move.

The resolution reads as follows:

**Resolution No. 15-76
OSMA Position on Public Law 93-641**

WHEREAS, Public Law 93-641, the "National Health Planning and Resource Development Act of 1974", is now law, and

WHEREAS, The Board of Trustees of the American Medical Association views Public Law 93-641 as "dangerous to the provision of quality medical care", and

WHEREAS, The House of Delegates of the American Medical Association at the 1975 annual convention supported "any action, including legal action", to prevent the implementation of Public Law 93-641, **THEREFORE BE IT**

RESOLVED, That the Ohio State Medical Association concurs with the position of the American Medical Association in opposition to Public Law 93-641, the "National Health Planning and Resource Development Act of 1974".

By official action, the House voted to adopt Resolution No. 15-76.

**Resolution No. 22-76
Absent Delegates**

The Resolutions Committee heard considerable debate regarding the concept of appointments to fill the position of delegates or alternate delegates who were not present at the official sessions of the House.

It was carefully noted that the Bylaws (Chapter 4, Section 2, page 6) state "in case a delegate or alternate delegate of a component society is unable to serve, the president or secretary of such society may, at any time, certify to the chairman of the Committee on Credentials, the name of an active member or member in training in good standing to serve in the place of such absent delegate or alternate delegate."



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The Committee felt that these provisions in the Bylaws provide an adequate method to fill vacancies created by absent delegates. It was not felt appropriate to appoint members from other county societies to fill the vacancies of another society.

Therefore, Mr. President, the Committee recommends that this resolution **not** be adopted.

By official action, the House voted to reject Resolution No. 22-76.

Resolution No. 23-76 Hospital Discharge Data Acquisition

The *Federal Register* of January 16, 1976, which promulgated the guidelines of the Hospital Discharge Data Acquisition was reviewed with great concern.

Testimony from President Maurice F. Lieber, M.D., to Michael Goran, M.D., Director of the Bureau of Quality Assurance, opposing HEW implementation was reviewed as was a letter from MEDCO Peer Review, Area One, to Dr. Goran and, likewise, a letter from the Academy of Medicine of Cleveland. All vigorously protested the proposed regulations.

Testimony from staff indicated that at this time there has been no announcement from HEW in regard to these regulations but it is apparent that HEW is rethinking the whole issue.

In light of the above, the Committee should like to strengthen the resolution by presenting Substitute Resolution No. 23 as follows:

Amended Substitute Resolution No. 23-76

WHEREAS, The *Federal Register* of January 16, 1976, regarding implementation of Hospital Discharge Data Acquisition is untenable to the medical profession in its present form, and

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WHEREAS, the President of the Ohio State Medical Association has gone on record opposing implementation of the HEW Uniform Hospital Discharge Abstract, **THEREFORE BE IT**

RESOLVED, That this House of Delegates strongly support the AMA's efforts to have HEW revise the Hospital Discharge Data Acquisition, and **BE IT FURTHER**

RESOLVED, That the local county medical societies be encouraged to register their complaints to HEW, and **BE IT FURTHER**

RESOLVED, That the Ohio State Medical Association report to the membership via the *Ohio State Medical Journal* and other bulletins, the progress in this and other actions regarding governmental directives implementing laws affecting the medical profession, or bills before Congress that deal with health care delivery or the medical profession/, and **BE IT FURTHER**

RESOLVED, THAT THE HOUSE OF DELEGATES OF THE OHIO STATE MEDICAL ASSOCIATION SUBMIT THIS RESOLUTION TO THE AMERICAN MEDICAL ASSOCIATION.

Mr. President, I move the adoption of Substitute Resolution No. 23-76.

By official action, the House voted to amend Substitute Resolution No. 23-76 as indicated by the strike-out deletion and by additions set forth in capital letters, then adopted it.

Resolution No. 24-76 Direct Billing

Mr. President, the Committee next heard testimony regarding direct billing activities of the House of Delegates in 1973 and 1974 as well as the recent case of a member who testified regarding the ruling in his favor of a court case dealing with direct billing of a welfare patient.

Guidelines to the Medicare regulations were likewise reviewed. Later in the course of testimony, information was presented to the Committee regarding the Talmadge amendments affecting Medicare and Medicaid reimbursements, which were introduced into the U.S. Senate on March 25, 1976. Because of the Talmadge bill, several additional amendments were suggested to the Committee.

It appeared crystal clear that the physicians testifying on this resolution felt strongly that physicians should be permitted to bill their patients for services rendered. It was also noted that the physician has the option not to direct bill his patient and take assignment, should he so choose.

Therefore, Mr. President, the Committee submits a Substitute Resolution as follows:

Substitute Resolution 24-76

WHEREAS, the Ohio State Medical Association has previously adopted a policy that defends the physician's right to bill his patient for services rendered (Resolution No. 23-73 and Resolution No. 44-74), and

WHEREAS, the policy of this House has provided an option for physicians to elect not to directly bill a patient for services rendered (Resolution 6-73), and

WHEREAS, a recent bill introduced in the U.S. Senate may attempt to interfere with the right of a physician to directly bill a patient who may be covered under a governmental program, THEREFORE BE IT

RESOLVED, That physicians should not be forced by law or regulations to accept assignment as payment in full from third party carriers, and that physicians should be encouraged to study carefully the implications of voluntarily accepting assignment, and BE IT FURTHER

RESOLVED, That laws or regulations which place ~~unfair~~ limitations on reimbursement of physicians ~~which do not recognize current inflationary pressures and rising costs of medical practice~~ be deemed improper and discriminatory, and BE IT FURTHER

RESOLVED, That this House of Delegates reaffirm the policy that physicians have the right to bill patients directly for services rendered regardless of any third party carrier, either private or governmental, with whom the patient has contracted, AND BE IT FURTHER

RESOLVED, THAT THE HOUSE OF DELEGATES OF THE OHIO STATE MEDICAL ASSOCIATION SUBMIT THIS RESOLUTION TO THE AMERICAN MEDICAL ASSOCIATION, AND BE IT FURTHER

RESOLVED, THAT A COPY OF THE RESOLUTION BE SENT TO EACH U.S. SENATOR AND TO EACH U.S. REPRESENTATIVE FROM OHIO.

Mr. President, I move that Substitute Resolution No. 24-76 be adopted.

By official action, the House voted to amend Substitute Resolution No. 24-76 as indicated by the strike-out deletion and by the additions set forth in capital letters, then adopted it.

Resolution No. 25-76 P.S.R.O.

The Committee considered Resolutions 25-76 and 38-76 together, both of which are on the subject of P.S.R.O.

Mr. President, I should like to indicate that approximately one and one-half hours of testimony were heard by this Resolutions Committee regarding these two resolutions on P.S.R.O.

The debate was stimulating, controlled, provocative, educational, and sometimes emotional. It was very apparent that many of those who gave testimony had spent much time and study of the issues at hand.

The actions of the House of Delegates at its Annual Meeting in 1975 were carefully reviewed before the entire group. The relationships between the P.S.R.O. and H.S.A. were developed for the edification of the Resolutions Committee.

After careful deliberation in executive session, it was felt that there was no possibility of being able to satisfy the needs and desires of all the physicians attending this delegation. Therefore, Mr. President, in the spirit of trying to build the strength of this fine organization, your Resolutions Committee should like to submit the following compromise substitute resolution:

Amended Substitute Resolution No. 25-76

WHEREAS, the House of Delegates in 1975, adopted the policy establishing the following guidelines regarding P.S.R.O.s, which are:

1. The Council is instructed to continue its efforts to achieve constructive amendments to P.L. 92-603, particularly in the areas of confidentiality, professional liability and development of norms of practice, quality of care and contest the authority of the Secretary of HEW.
2. ~~That the~~ The OSMA SHOULD continue its efforts to achieve legislation that allows the medical profession to perform peer review in accordance with the profession's philosophy and in the best interests of the patient.
3. COUNCIL IS DIRECTED ~~The direction of Council~~ to request MAI peer review systems to continue in consultative and supportive roles in developing medically oriented peer review programs, criteria and methodologies, including but not limited to programs which implement the review provisions of P.L. 92-603.



4. Component medical societies or individual members of the Ohio State Medical Association who elect **not** to participate in the implementation of P.L. 92-603 should not be precluded from adopting and maintaining such a position, but should be encouraged to develop effective non-P.S.R.O. peer review programs as constructive alternatives to P.S.R.O.
5. When evaluation of the P.S.R.O. program by either this House of Delegates or the Council reveals that it adversely affects the quality of patient care, or conflicts with the principles of medical ethics, the Council is instructed to use all professional and legal means to rectify the shortcomings of the P.S.R.O. program, and

WHEREAS, the funding mechanism for implementation of P.S.R.O.s has been given low priority by Congress, and
WHEREAS, the activities of P.S.R.O. units throughout the country have been extremely slow in starting, both in the planning phases as well as conditional phases, and
WHEREAS, the non-P.S.R.O. peer review activities of physicians working in hospitals throughout this state have had a beneficial impact on the quality of care and utilization trends, THEREFORE BE IT

RESOLVED, That the House of Delegates reaffirm its previous policy and guidelines of the 1975 session, as noted above, and BE IT FURTHER

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RESOLVED, That the Ohio State Medical Association not actively engage in any new programs to enhance the government's P.S.R.O. program but lend its strength and expertise to the continued development of non-P.S.R.O. peer review, and BE IT FURTHER

RESOLVED, That each MEMBER ~~Delegate~~ of this Association shall be kept informed of Council's activities in P.S.R.O. matters and updates of activities, INCLUDING COSTS, of the P.S.R.O. organizations in our state.

Mr. President, I move the adoption of this Substitute Resolution No. 25-76.

By official action, the House voted to amend Substitute Resolution No. 25-76 as indicated by the strike-out deletions and by the additions set forth in capital letters, then adopted it.



Resolution No. 26-76
National Health Insurance

The Committee next heard testimony regarding national health insurance.

There was active discussion and concern provided to the Committee. Past actions of the House of Delegates regarding support of the Medicaid Bill in 1971 were reviewed and the recent action of the AMA Annual Meeting in 1975 supporting H.R. 6222, to be made available through the private insurance industry, was discussed.

It is apparent from the discussion that programs providing health insurance for the poor were necessary and needed. Concern was voiced regarding the high cost of providing health care to those who could afford it.

Mr. President, the Committee should like to offer Substitute Resolution No. 26-76 as follows:

Substitute Resolution No. 26-76

WHEREAS, Universal and Compulsory National Health Insurance would ultimately lead to socialized medicine, and

WHEREAS, it is believed that socialized medicine could, in a relatively short period, result in deterioration of rather than improvement in medical care, and

WHEREAS, quality of health may be better served by using monies for programs directed toward improving quality of life, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association request the American Medical Association to oppose all forms of universal and compulsory national health insurance, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association request the Ohio Congressional Delegation, likewise, to oppose all forms of universal and compulsory national health insurance.

Mr. President, I move the adoption of this Substitute Resolution No. 26-76.

After lengthy discussion, the House voted to table Resolution No. 26-76 and Substitute Resolution No. 26-76.

Resolution No. 34-76 **Physician Registration**

Mr. President, the Committee next heard debate regarding physician registration as it applies to renewal of medical licenses.

There appeared to be considerable confusion of a significant number of physicians in the State of Ohio regarding this required registration. Testimony was heard from members of the Ohio State Medical Board.

It was felt the passage of this resolution and the combined efforts of the OSMA and the Ohio State Medical Board could relieve this confusion and prevent the multiple problems that might occur with late or missed registration.

Therefore, Mr. President, your Resolutions Committee recommends adoption of Resolution 34-76.

The resolution reads as follows:

Resolution No. 34-76 **Physicians Registration**

WHEREAS, It is the responsibility of the Ohio State Medical Board to notify all physicians of their need to renew their license to practice medicine by mailing an application on the first day of October each even-numbered year; and

WHEREAS, The licensed physician within the State of Ohio is required to apply for a Certificate of biennial registration to the Ohio State Medical Board on or before the first day of January of each odd-numbered year; and

WHEREAS, Problems have been created when physicians have failed to receive the proper notification to renew their license to practice medicine; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association develop and implement in cooperation with the Ohio State Medical Board an accurate and efficient procedure whereby physicians can be notified in a timely manner so that they can renew their license to practice medicine in accordance with the Statutory Regulation. (Section 4731.281 — *Ohio Revised Code*)

By official action, the House voted to adopt Resolution No. 34-76.

Resolution No. 36-76 **Abortion**

Mr. President, this next issue dealt with abortion. As was anticipated, there was much discussion, sincere concern and mixed feelings represented in the testimony heard. Those testifying represented obstetricians, pediatricians, family physicians, and other specialties as well as concerned members.

In executive session, your Committee realized that the tremendous conflict regarding the problems centered around abortion could not be solved by this House of Delegates. The rulings of the Supreme Court were reviewed and it was sincerely felt that this issue, based on those rulings, must continue to rest in the conscience and rights of the individual patient and her physician.

After much deliberation, the Committee decided that further testimony on the floor of the House of Delegates at this time would not substantially change nor alter the opinions of the voting delegates, therefore, Mr. President, I move that Resolution 36-76 not be adopted.



By official action, the House voted that Resolution No. 36-76 be postponed indefinitely.

**Resolution No. 43-76
Redistricting the Ohio State Medical Association**

Mr. President, the Committee next addressed itself to the issue regarding redistricting of Ohio State Medical Association into the H.S.A. areas.

No testimony was provided by the Holmes County Medical Society and the testimony was heavily against support for this resolution.

The committee recommends that Resolution No. 43-76 not be adopted and I so move.

By official action, the House voted to reject Resolution No. 43-76.

**Resolution No. 47-76
Nomination and Election of District Councilors**

Mr. President, the Resolutions Committee heard, in quite some detail, testimony regarding this resolution.

As the House will recall, last year a Resolution No. 37-75, was passed by this body. This resolution directed that a special committee on Constitution and Bylaws prepare a resolution containing specific language for introduction at this meeting of the House of Delegates.

There was some confusion regarding this issue. However, the resolution we are now considering is in response to the charge for development of specific language rather than changing the method of nominating district councilors which was previously passed in the last House of Delegates in 1975. Concern was expressed by those who testified that the opportunity for election as district councilor be made available to qualified physicians. The Committee feels that the wordage in this resolution not only assures the proper method of nominations for councilors, but, in fact, will provide more opportunities for physicians to run for the position of councilor.

Several non-substantive changes have been made to the resolution and the Committee accordingly recommends adoption of the amended resolution as follows:

Amended Resolution No. 47-76

RESOLVED, That Chapter 5 of the Bylaws of the Ohio State Medical Association be amended by the addition of the following section, which shall be Section 4 of Chapter 5:

Section 4. Nomination and Election of District Councilors; Nominations for the office of district councilor shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names

have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirement shall be waived as hereinafter provided; that the name or names of a candidate or candidates for the office of councilor must be filed by the caucus of that district's delegates with the Executive Director of the Association prior to the opening of the first session of the House of Delegates in Annual Meeting, and that no nomination for councilor may be presented at any meeting unless the foregoing has been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two thirds (2/3rds) of the delegates present at the opening session of such meeting. BE IT FURTHER

RESOLVED, That the present Chapter 5, Section 4 be re-numbered Chapter 5, Section 5; that Section 5 be re-numbered Section 6; Section 6 be Section 7 and Section 7 be re-numbered Section 8.

Mr. President, I move this amended resolution be adopted.

By official action, the House voted to adopt Amended Resolution No. 47-76.

In completing the report of the Committee I should like to take note of the quality and depth of testimony presented to our Committee. It was most impressive to us to observe the preparation of many of those who gave testimony and the amount of time they had taken to study the issues presented.

We were pleased to receive testimony from medical students, members of Council, past presidents, physicians from rural areas, and those from large cities.

(Proceedings continued page 418)

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We should like to report that each physician was allowed to be heard, and the audience was attentive to all. The assistance of staff in providing the background information was most helpful.

Mr. President, I would like to personally thank you for appointing a well-balanced, knowledgeable Committee whose input and direction has been most helpful in preparing this report. I should like to personally thank Dorothy Wilgus for her long hours of preparing this report, and I should like to request that the members of my Committee stand as I read their names.

Mr. President, I move that this report of Resolutions Committee No. 2 be adopted.

Respectfully submitted, Resolutions Committee No. 2: James M. Smith, Butler County; Ernest H. Winterhoff, Clark County; Robert Elliott, Hardin County; John F. Bodie, Ottawa County; Theodore J. Castele, Cuyahoga County; Raymond J. McMahon, Jr., Stark County; Robert R. Johnson, Coshocton County; Robert A. Ringer, Guernsey County; John W. Zimmerly, Jackson County; Joseph A. Bonta, Franklin County; A. Burney Huff, Wayne County; Fred F. Somma, Summit County; and Frederick T. Suppes, Cuyahoga County, Chairman.

The report of Resolutions Committee No. 2, as a whole, as amended, was approved by the House.



REPORT OF RESOLUTIONS COMMITTEE NO. 3

Resolutions Committee No. 3 met in open hearing for approximately three and one-half hours and considered 15 resolutions. Numerous individuals presented their opinions of the various resolutions and the Chairman wishes to thank those who took the time and effort to come and express their opinions. They gave the Committee valuable information regarding the resolutions as presented. The Chairman also wishes to thank the medical students who attended the meetings and who also entered into the discussion of several resolutions.

Amended Resolution No. 4-76 Advertising

The Committee studied this resolution thoroughly and made a slight change in the third Whereas. It should read:

WHEREAS, The ethics of the medical profession as stated in the *Principles of Medical Ethics*, including Section 5 (which states that a physician should not solicit patients) has effectively guided doctors of medicine for over 200 years; and

WHEREAS, Patients should seek the services of a physician on the basis of need rather than in response to a contrived marketing program; and

WHEREAS, Contrary to statements by the Federal Trade Commission, advertising is likely to encourage over-utilization, thereby increasing the cost of health care in this nation;

RESOLVED, That the Ohio State Medical Association vigorously support the American Medical Association in the complaint filed against it by the Federal Trade Commission.

Mr. President, the Committee recommends the resolution be approved as amended and, Mr. President, I so move.

By official action, the House voted to adopt Amended Resolution No. 4-76.

Amended Resolution No. 5-76 Regulation of Emergency Ambulance Services

WHEREAS, Adequately trained ambulance personnel reduce the need for excessive speed; and

WHEREAS, The Joint Medical Safety Committee of the National Safety Congress has reported that "Speed is seldom if ever a factor in the preservation of a life and speeding ambulances result in more additional traffic deaths than in lives saved." THEREFORE BE IT

RESOLVED, That all ambulance drivers should comply with traffic laws applicable to non-emergency vehicles, AND BE IT FURTHER

RESOLVED, That effective 1978, all ambulance services should hire only personnel who have certified EMT status in the State of Ohio, and by 1979, existing personnel should be required to obtain EMT certification.

Mr. President, the Committee voted that Amended Resolution No. 5-76 be adopted and, Mr. President, I so move.

By official action, the House voted to reject Amended Resolution No. 5-76.

Resolution No. 11-76 OSMA-Sponsored Courses in English and Basic Sciences for Foreign Medical Graduates

The Committee heard considerable testimony on this resolution, both pro and con; and the Committee considered the resolution thoroughly. It was the opinion of the Committee that the resolution be not adopted, but that component societies should sponsor the courses, if desired, in the same manner as the Academy of Medicine of Cleveland has done. Component societies desiring further information on this program might well contact the Academy of Medicine of Cleveland.

Mr. President, the Committee therefore voted that Resolution No. 11-76 be **not** adopted, and, Mr. President, I so move.

By official action, the House voted to reject Resolution No. 11-76.

Resolution No. 13-76 "Assignment" Opposed

The Committee heard considerable testimony regarding this resolution. It did not appear that the subject of the resolution was primarily that of medical society affairs and, in addition, there had been no request nor desire for such resolution from the institutions concerned nor was evidence presented of harm to these institutions.



Mr. President, it is the recommendation of the Resolutions Committee that Resolution No. 13-76 be **not** adopted and, Mr. President, I so move.

By official action, the House voted to reject Resolution No. 13-76.

Amended Resolution No. 14-76 Smoking Ban in Hospitals

This resolution is presented with the following amendments.

BE IT RESOLVED, That the Ohio State Medical Association encourage hospital administrations and medical staffs to ban smoking in hospitals, except in specifically designated areas; **AND BE IT FURTHER RESOLVED**, That a copy of this resolution be sent to **THE OHIO HOSPITAL ASSOCIATION AND TO** all hospital administrators in the State of Ohio.

Mr. President, the Committee recommends that Amended Resolution No. 14-76 be adopted, and, Mr. President, I so move.

By official action, the House voted to adopt Amended Resolution No. 14-76, as amended.

Amended Resolution No. 16-76 Official Representative of Organized Medicine

This resolution is presented with amendments:

WHEREAS, The American Medical Association has recently shown both the ability and desire to effectively represent organized medicine in its relations with outside influences, and
WHEREAS, The fragmentation of the voice of medicine is to be avoided as reducing the effectiveness and increasing costs, **THEREFORE BE IT**



RESOLVED, That the Ohio State Medical Association reaffirm its position that the most effective representation of organized medicine, as well as of the individual physician, is through a strong relationship of the American Medical Association, the State Medical Societies and their component societies.

Mr. President, the Resolutions Committee recommends that Amended Resolution No. 16-76 be adopted, and, Mr. President, I so move.

By official action, the House voted to adopt Amended Resolution No. 16-76.

Amended Resolution No. 27-76 The Patient Speaks

This resolution was amended as follows:

WHEREAS, The patient plays an integral part in the Doctor, Nurse, Hospital, Paramedical and Patient Team in the ultimate goal of rendering and receiving optimum medical care; and

WHEREAS, The patient may receive better medical care when he is given the opportunity to express observations of constructive criticism to the Administration, Doctor, Nurse, Paramedical Team, **THEREFORE BE IT**

RESOLVED, That the House of Delegates of the Ohio State Medical Association recommend to the Ohio Hospital Medical Staffs, Administrators, and Nursing Staffs that they join cooperatively to offer **PATIENTS A MEANS TO meetings on a periodic basis, wherein a panel of patients and a moderator may** bring their observations to the attention of the above professions, in an effort to upgrade medical care.



Mr. President, the Committee recommends that Amended Resolution No. 27-76 be adopted, and, Mr. President, I so move.

By official action, the House voted to amend Amended Resolution No. 27-76 as indicated, and adopted it.

Resolution No. 28-76 Free Enterprise Coalition Citizens-Physicians- Hospital Administrators-Boards of Trustees

The members of the Committee studied this resolution thoroughly, including the testimony given. It was felt that the resolution did not add anything to action which had previously been determined or decided by the House of Delegates.

Mr. President, it is the recommendation of the Resolutions Committee that Resolution No. 28-76 be **not** adopted, and, Mr. President, I so move.

By official action, the House voted to reject Resolution No. 28-76.

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Resolution No. 32-76 Commendation for Richard Meiling, M.D.

The Committee found this Resolution No. 32-76 proper and acceptable as submitted and voted unanimously that it be adopted, and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, Doctor Richard Meiling, member of the American Medical Association Council on Long Range Planning and Development, in the face of strong administrative opposition, put forth a minority report in regard to reorganization of the American Medical Association which maintained the status quo of the original federation concept; and
WHEREAS, This was essentially adopted by the American Medical Association House of Delegates in Hawaii 1975:
THEREFORE BE IT
RESOLVED, That Doctor Richard Meiling be commended for his efforts and diligence in preserving the concept that the American Medical Association is in principle a federation of state societies and should so remain.

By official action, the House voted to adopt Resolution 32-76.

Substitute Resolution No. 33-76 Establishment of Culture Committee

The Committee exercised its prerogative of submitting a Substitute Resolution No. 33-76 to read as follows:

WHEREAS, Increasingly, major Medical societies are combining art exhibits with their annual Medical scientific meetings, and
WHEREAS, The Ohio State Medical Association has already embarked on successful art exhibits at some of its recent OSMA meetings; THEREFORE BE IT
RESOLVED, That the Council of the Ohio State Medical Association establish a subcommittee of the Committee on Scientific Work to be entitled "Arts Subcommittee," whose function will be to encourage cultural and artistic pursuits by the membership.

Mr. President, I move adoption of Substitute Resolution No. 33-76.

By official action, the House voted to adopt Substitute Resolution No. 33-76.



Amended Resolution No. 37-76 Congratulations to AMA

The Committee considered this resolution and it was amended as follows:

WHEREAS, The American Medical Association in recent court action against the Department of Health, Education and Welfare forced the Secretary of HEW to withdraw its Utilization Review Regulations; and
WHEREAS, This activity is in contrast to previous conciliation and compromise exhibited by the AMA in such matters as PSRO, THEREFORE BE IT
RESOLVED, The Ohio State Medical Association extends its congratulations and thanks to the officers and administrative staff of the American Medical Association for their courageous and successful effort; and BE IT FURTHER

The second Resolved is changed as follows:

RESOLVED, The Ohio State Medical Association endorses with enthusiasm the announced intent of the AMA to take similar legal action, when indicated, to protect the medical profession from the encroachment of the Federal Government.

Mr. President, it is the recommendation of the Resolutions Committee that Amended Resolution 37-76 be adopted as amended, and, Mr. President, I so move.

By official action, the House voted to adopt Amended Resolution No. 37-76.

Resolution No. 40-76 Determination of Death

After thorough discussion in executive session, the Resolutions Committee voted unanimously to accept this resolution as written and recommends its adoption.

Mr. President, it is the recommendation of the Resolutions Committee that Resolution No. 40-76 be adopted, and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, The interest of the patient, society and the physician would be harmed by the establishment of rigid legal criteria of death; THEREFORE BE
RESOLVED, That the Ohio State Medical Association oppose any legislated definition of death; and BE IT FURTHER
RESOLVED, That the determination of death be made by the attending physician based on sound medical judgment.

By official action, the House voted to adopt Resolution No. 40-76.

(Proceedings continued page 423)



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1. Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976. See reverse side for prescribing information.



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Bedford, Massachusetts 01730

House of Delegates' Proceedings

Amended Resolution No. 41-76 Licensing of Physician's Assistants

This resolution evoked the greatest interest and the greatest discussion of any of the resolutions to come before this Committee. The Chairman of the Committee reminded the members of the Committee and also those present to testify in regards to Resolution No. 41-76, that H.B. 663, which had been amended and was then introduced as Sub. H.B. 663, had been passed by the Ohio House of Representatives and the Ohio Senate and was awaiting the Governor's signature. Testimony was then presented in regards to the Sub. H.B. 663, and changes were advocated. A great deal of discussion both pro and con was heard. At the executive session, a very thorough discussion of Resolution 41-76 and a suggested substitute resolution was undertaken. It was the consensus of the Resolutions Committee that because the bill is new and has not yet been implemented, that any attempt at changes would be premature. It was also felt by members of the Committee that some of the proposed changes were inappropriate because of the wording of Sub. H.B. 663. The best approach appeared to be to adopt a "wait and see" attitude, with the idea that if certain items in the bill proved to be difficult or unworkable, that changes in the bill could be proposed at the next session of the House of Delegates.

The Resolutions Committee voted to **not** adopt Resolution 41-76, and to **not** adopt any substitute resolution, and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 41-76.**

A substitute resolution was then introduced by the Academy of Medicine of Cleveland, and it was defeated by the House.



Amended Resolution No. 42-76 Maximum Allowable Cost Regulations

The Committee considered Resolution No. 42-76 and changes were recommended in the third Whereas as follows:

WHEREAS, The Regulations regarding Maximum Allowable Cost for drugs published in the Federal Register requires "physician certification" as to the medical necessity for a given form of a drug before reimbursement in an amount in excess of the lowest cost for that class of drugs is permitted, and

WHEREAS, Each prescription written by a physician in and of itself identifies a medicine or combination of medicines which he or she judges to be necessary for that patient's mental or physical condition, and

WHEREAS, The best interest of the patient's medical care is served by recognition of the fact that the physician is the sole determiner of the proper drug therapy for a given patient's condition.

RESOLVED, That the OSMA reaffirm its policy that the physician is the sole determiner of which medicine his patient receives, and, **BE IT FURTHER**

The final Resolved is changed as follows:

RESOLVED, That the OSMA insists that each physician prescription will be filled precisely as written, regardless of any third party regulation, and without the necessity of certification of each and every prescription which may or may not fall under the purview of the Maximum Allowable Cost Regulations.

Mr. President, it is the recommendation of the Resolutions Committee that Amended Resolution No. 42-76 be adopted, and, Mr. President, I so move.

By official action, the House **voted to adopt Amended Resolution No. 42-76.**

Resolution No. 46-76 Persecution of Religious Minorities

The Committee was in sympathy with the intent of the resolution. However, it was felt that it was not the function of the Ohio State Medical Association to become involved with this type of resolution and the members felt that a broad-based substitute resolution would not serve any useful purpose; not because of the principle of the resolution, but because it appeared to the Committee that the resolution was not germane to the purposes of the Ohio State Medical Association as expressed in its Constitution.

(Proceedings continued page 424)

"Current Concepts in Alcoholism"

Co-sponsored by

Academy of Medicine of Cleveland
and

Merrick Hall, Woman's General Hospital

Date: September 15, 1976, from 7:30 AM to 5 PM.

Location: Park Plaza Hotel.

Registration Fee (includes lunch): Attending Physician \$30, House Staff Officers and Fellows \$15, Medical Students \$7, Non-Physicians \$30.

Topics include: "Current Concepts in Alcoholism"—Maxwell N. Weisman, M.D.; "Analgesics and Psychoactive Drugs in the Care of Medical Patients"—Douglas McDonald, M.D.; "The Role of the Physician in Treating the Alcoholic"—Gregory B. Collins, M.D.; "The Disabled Physician"—LeClaire Bissel, M.D.; and "The Woman Alcoholic"—Robert Bowman, M.D.

For further information contact: Academy of Medicine of Cleveland, 10525 Carnegie Ave., Cleveland, Ohio 44106, Telephone: 216/231-3500.

House of Delegates' Proceedings

Mr. President, it is the recommendation of the Committee that Resolution No. 46-76 be **not** adopted, and, Mr. President, I so move.

By official action, the House voted to reject Resolution No. 46-76.

The Chairman deeply appreciates the diligence and cooperation of all the members of the Committee. Each member gave generously of his time and put forth great effort, thus allowing for smooth and efficient operation of the Committee at all times.

I would also like to thank our legal counsel and the OSMA staff and its secretaries, especially Catherine Keeling, for their assistance in producing this report.

Mr. President, I respectfully submit and move adoption of the Report of Resolutions Committee No. 3, members of which are shown on the attached signature page.

Respectfully submitted, Resolutions Committee No. 3: Glenn B. Doan, Highland County; John H. Taylor, Montgomery County; Walter A. Daniel, Seneca County; Peter A. Overstreet, Lucas County; Wesley J. Pignolet, Lake County; William Banfield, Columbiana County; Donald R. Piatt, Monroe County; Walter B. Devine, Muskingum County; Chester H. Allen, Scioto County; David J. Hickson, Morrow County; S. Baird Pfahl, Jr., Erie County; F. Michael Sheehan, Portage County; and Edward E. Grable, Stark County, Chairman.

The report of Resolutions Committee No. 3, as a whole, as amended, was approved by the House.

INAUGURAL CEREMONY

Mrs. Lieber was introduced and escorted to the podium by Dr. P. John Robeck. Dr. Henry then presented President's medallion pins to Dr. and Mrs. Lieber and the certificate of honor to Dr. Lieber.

Mrs. Bates and their six children were asked to come to the podium. After they were introduced to the House, Dr. Henry administered the presidential oath of office to Dr. Bates; and Dr. Lieber, retiring President, presented to Dr. Bates the official gavel and the President's medallion. Dr. Bates presented to Dr. Lieber the Past-President's button.



REMARKS BY DR. BATES

Dr. Bates addressed the House of Delegates. His speech was entitled "A Sense of Ending, A Sense of Beginning." (See text of address in this issue.)

COMMITTEES NAMED

Dr. Bates presented the following standing committee appointments, and they were officially approved by the House of Delegates:

Committee on Education—Dr. Howard S. Madigan, Sylvania, appointed Chairman for ensuing year; Dr. Stanley W. Olson, Kent, appointed member of the Committee for a five-year term.

Committee on Judicial and Professional Relations—Dr. Homer A. Anderson, Columbus, reappointed Chairman for ensuing year; Dr. John A. Devany, Toledo, appointed member of the Committee for a five-year term.

Committee on Membership and Planning—Dr. William R. Schultz, Wooster, reappointed Chairman for ensuing year; Dr. Oscar W. Clarke, Gallipolis, reappointed for a term of five years.

Committee on Public Relations—Dr. Luther W. High, Millersburg, reappointed Chairman for ensuing year; Dr. Thomas R. Leech, Lima, appointed member of the Committee for a five-year term.

Committee on Scientific Work—Dr. John E. Albers, Cincinnati, reappointed Chairman for ensuing year; Dr. Jerry L. Hammon, West Milton, reappointed member of the Committee for a term of five years; Dr. John F. Kroner, Athens, appointed member of the Committee for a term of five years.

MISCELLANEOUS

Dr. Robeck was introduced and gave a few remarks on the drive for AMA membership and the Budd Campaign.

Dr. W. J. Lewis, Dayton, asked for the floor to propose a motion thanking the host city, Cincinnati, and Gail Dodson, the convention coordinator, for another great Annual Meeting. The motion was **adopted**.

There being no further business, the House of Delegates then adjourned sine die.

ATTEST: Hart F. Page
Executive Director

OSMA Annual Meeting Registration 1919 to 1976

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.: Mis. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1818
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with AMA						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			411	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	185	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535
1959	Columbus	1359	293	445	721	364	3182
1960	Cleveland	1642	489	48	1026	447	3652
1961	Cincinnati	1256	231	24	751	301	2563
1962	Columbus	1304	265	343	736	371	3019
1963	Cleveland	1502	336	19	893	441	3191
1964	Columbus	1428	332	297	1002	376	3435
1965	Columbus	1330	275	335	968	394	3302
1966	Cleveland	1484	309	22	865	355	3035
1967	Columbus	1327	286	394	1178	405	3590
1968	Cincinnati	1300	230	35	1287	613	3465
1969	Columbus	1344	219	208	1780	518	4069
1970	Columbus	1160	189	224	1355	477	3405
1971	Columbus	1049	159	182	1116	451	2957
1972	Cincinnati	1118	204	37	1172	498	3029
1973	Columbus	1100	130	93	1260	431	3014
1974	Cleveland	1048	101	26	1010	405	2590
1975	Columbus	1058	147	52	1087	393	2737
1976	Cincinnati	1022	115	67	1124	304	2723

OSMA House of Delegates

Attendance of Delegates

1976 Annual Meeting

COUNTY	DELEGATE	FIRST SESSION	SECOND SESSION	COUNTY	DELEGATE	FIRST SESSION	SECOND SESSION
FIRST DISTRICT				LOGAN	Charles L. Barrett	x	x
ADAMS	Francis L. Stevens		x	MARION	Paul E. Lyon	x	x
BROWN	John R. Donohoo	x		MERCER	James J. Otis	x	x
	A. J. Pasquale		x	SENECA	Walter A. Daniel	x	x
BUTLER	Jerry D. Hammond	x	x	VAN WERT	Alford C. Diller	x	x
	James M. Smith	x	x	WYANDOT			
	James F. Stewart	x	x				
CLERMONT	Carl A. Minning	x	x	FOURTH DISTRICT			
CLINTON	Foster J. Boyd	x	x	DEFIANCE	Ben Lenhart		x
HAMILTON	John E. Albers	x	x	FULTON	Benjamin H. Reed, Jr.	x	x
	Eugene J. Burns	x	x	HENRY	Robert J. Blough	x	x
	Edmund C. Casey	x	x	LUCAS	John A. Devany	x	x
	Neal N. Earley	x	x		Roland A. Gandy, Jr.	x	x
	Charles D. Feuss, Jr.	x	x		B. Leslie Huffman	x	x
	George D. J. Griffin	x	x		M. Brodie James	x	
	Robert S. Heidt		x		Thomas J. O'Grady	x	x
	Harry K. Hines	x	x		Peter A. Overstreet	x	x
	Stanley J. Lucas	x	x		Robert N. Smith		x
	H. Glenn Overley	x			Harry L. Snyder	x	
	Glenn W. Pfister	x	x		Richard J. Wiseley		x
	William J. Schrimpf	x	x	OTTAWA	John F. Bodie	x	x
	Andrew J. Weiss	x	x	PAULDING	Doyt E. Farling	x	x
	Stewart B. Dunsker	x	x	PUTNAM	James B. Overmier	x	x
HIGHLAND	Glenn B. Doan	x	x	SANDUSKY	Samuel R. Lowery	x	x
WARREN	Thomas E. Fox	x	x	WILLIAMS	John E. Moats		x
				WOOD	Douglas S. Hess	x	x
SECOND DISTRICT							
CHAMPAIGN	Isador Miller	x	x	FIFTH DISTRICT			
CLARK	Henry A. Diederichs		x	ASHTABULA			
	Ernest H. Winterhoff		x	CUYAHOGA	Donavin A. Baumgartner, Jr.	x	x
DARKE	Jose R. Solis	x	x		Matthew R. Biscotti		x
GREENE	Antonio D. Mannarino		x		Edward J. Bishop		x
MIAMI	A. Robert Davies	x	x		John H. Budd	x	
MONTGOMERY	R. Alan Baker	x	x		Charles L. Cassady	x	x
	John H. Boyles, Jr.	x	x		Theodore J. Castele	x	x
	A. Julian Gabriele	x	x		Henry A. Crawford	x	x
	Robert K. Finley, Jr.	x	x		Clarence L. Huggins, Jr.	x	x
	Richard G. Jenkins	x			Edward G. Kilroy	x	x
	Wallace E. Johnson	x			Steven Kovacs	x	x
	Frederic C. Schnebly	x	x		Vincent T. LaMaida	x	x
	John H. Taylor	x	x		George P. Leicht	x	
	John R. Whitaker, Jr.		x		Leonard L. Lovshin	x	x
	John Worthman		x		Lawrence J. McCormack	x	x
PREBLE	Chester J. Brian		x		Russell J. Nicholl	x	
SHELBY	George J. Schroer	x	x		Richard J. Nowak	x	x
					Thomas P. Paras	x	x
THIRD DISTRICT					George W. Petznick	x	x
ALLEN	David A. Barr	x	x		John G. Poulos		x
	Joseph M. Oppenheim	x	x		P. John Robeck	x	x
AUGLAIZE	David Neilson	x	x		A. Benedict Schneider	x	x
CRAWFORD	Johnson H. Chow	x	x		Howard S. Siegel	x	x
HANCOCK	William H. Kose	x	x		Franklyn J. Simecek	x	x
HARDIN	Robert Elliott	x	x		Frederick T. Suppes	x	x
					Warner W. Tuckerman	x	
					Howard Van Ordstrand		x

COUNTY	DELEGATE	FIRST SESSION	SECOND SESSION	COUNTY	DELEGATE	FIRST SESSION	SECOND SESSION
GEAUGA	Bruce F. Andreas	x	x		Frederick M. Kapetansky	x	
LAKE	John A. Bukovnik	x	x		John N. Meagher		x
	Wesley J. Pignolet	x	x		George W. Paulson	x	x
					H. William Porterfield	x	x
	SIXTH DISTRICT				Jack E. Tetirick	x	x
COLUMBIANA	William Banfield	x	x	KNOX	James C. McLarnan	x	x
MAHONING	John J. Anderson	x	x	MADISON			
	John Melnick	x	x	MORROW	David J. Hickson	x	x
	Jack Schreiber	x	x	PICKAWAY	Robert G. Smith	x	x
	William E. Sovik	x	x	ROSS	J. S. McKell	x	x
STARK	Edward J. Davis	x	x	UNION	Lawrence Gould	x	
	Edward E. Grable	x	x				
	Raymond J. McMahon, Jr.	x	x		ELEVENTH DISTRICT		
	William A. White, Jr.	x	x				
TRUMBULL	Joseph L. Logan	x	x	ASHLAND	Jon Cooperrider	x	x
	Joseph Sudimack		x	ERIE	S. Baird Pfahl, Jr.	x	x
	SEVENTH DISTRICT			HOLMES	Luther W. High	x	x
BELMONT	Felipe V. Lavapies	x	x	HURON	Nino M. Camardese	x	x
CARROLL	Carl A. Lincke	x		LORAIN	Charles G. Adams	x	x
COSHOCTON	Robert R. Johnson	x	x		Delbert L. Fischer	x	x
HARRISON	Janis Trupovnieks		x	MEDINA	Thomas Sfiligoj	x	x
	Elias Freeman	x		RICHLAND	Richard W. Avery	x	x
JEFFERSON	Irving Dreyer	x	x		James F. Clements	x	x
MONROE	Donald R. Piatt	x	x		Harold F. Mills		x
TUSCARAWAS	Philip T. Doughnten	x	x	WAYNE	James W. Wiggin	x	
					A. Burney Huff	x	x
	EIGHTH DISTRICT						
ATHENS	John F. Kroner	x	x	PORTAGE	F. Michael Sheehan	x	x
FAIRFIELD	James A. Merk	x	x	SUMMIT	Rocco Antenucci	x	x
GUERNSEY	Robert A. Ringer	x	x		C. V. Bowen	x	
LICKING	John P. Anderson	x	x		Roy E. Bugay		x
MORGAN	Henry Bachman	x			R. H. Champion	x	x
MUSKINGUM	Walter B. Devine	x	x		Warren P. Kilway	x	x
NOBLE					Joseph L. Kloss	x	
PERRY					E. Gates Morgan		x
WASHINGTON	Gregory Krivchenia	x	x		Fred F. Somma	x	x
					M. R. Werner	x	x
	NINTH DISTRICT						
GALLIA	Thomas P. Price, Jr.	x			OFFICERS		
	Edward J. Berkich		x		(Members of the Council)		
HOCKING	Lethia Starr	x	x	President	Maurice F. Lieber	x	x
JACKSON	John W. Zimmerly	x	x	President-Elect	George N. Bates	x	x
LAWRENCE	A. Burton Payne	x	x	Past President	James L. Henry	x	x
MEIGS	Roger Daniels	x	x	Secretary-	William M. Wells	x	x
PIKE				Treasurer			
SCIOTO	Chester H. Allen	x	x	First District	Stephen P. Hogg	x	x
VINTON				Second District	W. J. Lewis	x	x
	TENTH DISTRICT			Third District	John C. Smithson	x	x
DELAWARE	David R. Smith, Jr.	x	x	Fourth District	C. Douglass Ford	x	x
FAYETTE				Fifth District	John J. Gaughan	x	x
FRANKLIN	Homer A. Anderson	x		Sixth District	C. Edward Pichette	x	x
	Michael A. Anthony		x	Seventh District	Robert E. Rinderknecht	x	x
	Ben Arnoff	x		Eighth District	Richard E. Hartle	x	x
	Robert C. Atkinson	x	x	Ninth District	Thomas W. Morgan	x	x
	Joseph A. Bonta	x	x	Tenth District	J. Hutchison Williams	x	x
	Richard L. Fulton		x	Eleventh District	Robert G. Thomas	x	x
	Walter M. Haynes	x	x	Twelfth District	William Dorner, Jr.	x	x
					TOTAL	163	168

(Annual meeting continued page 428)

Annual Meeting Attendance

1976 Annual Meeting Registration by Counties With OSMA Membership Data

ATTENDANCE AT THE 1976 OSMA Annual Meeting included member physicians from 83 of Ohio's 88 counties. In all, 1,022 members of the Association were present. In addition, 115 guest physicians and 67 medical students attended, making a total of 1,204 physicians and future physicians. Persons registered as scientific, health education, and technical exhibitors numbered 304. Also present were 1,124 persons registered as members of the Auxiliary, nurses, technicians, other professional personnel, and miscellaneous guests. The total attendance was 2,723.

Following are tabulated figures on Annual Meeting attendance.

County	MEMBERSHIP		Annual Mtg. Registration	County	MEMBERSHIP		Annual Mtg. Registration
	Dec. 31, 1975	May 5, 1976			Dec. 31, 1975	May 5, 1976	
Adams	11	11	1	Logan	22	21	1
Allen	141	140	17	Lorain	234	221	18
Ashland	31	29	4	Lucas	681	626	43
Ashtabula	60	62	3	Madison	15	16	4
Athens	38	42	3	Mahoning	360	346	16
Auglaize	18	15	1	Marion	94	83	9
Belmont	64	62	6	Medina	56	55	1
Brown	18	17	4	Meigs	5	5	2
Butler	201	203	30	Mercer	18	15	2
Carroll	9	8	1	Miami	68	68	8
Champaign	14	11	3	Monroe	4	4	1
Clark	146	139	13	Montgomery	724	718	83
Clermont	22	20	8	Morgan	4	4	1
Clinton	24	24	5	Morrow	7	7	2
Columbiana	81	65	5	Muskingum	82	84	11
Coshocton	19	21	1	Noble	2	2	0
Crawford	36	38	2	Ottawa	26	22	2
Cuyahoga	2,266	2,107	84	Paulding	8	6	1
Darke	28	28	2	Perry	7	7	0
Defiance	30	29	3	Pickaway	21	20	6
Delaware	26	25	3	Pike	15	20	0
Erie	71	69	2	Portage	68	67	5
Fairfield	50	52	9	Preble	7	6	1
Fayette	14	13	1	Putnam	6	7	3
Franklin	997	907	106	Richland	137	133	14
Fulton	17	16	1	Ross	47	47	7
Gallia	37	29	6	Sandusky	48	48	4
Geauga	32	37	1	Scioto	75	67	6
Greene	56	53	6	Seneca	43	39	4
Guernsey	26	33	2	Shelby	20	20	3
Hamilton	1,394	1,237	312	Stark	387	359	17
Hancock	47	49	4	Summit	655	628	18
Hardin	23	25	1	Trumbull	154	144	8
Harrison	9	10	2	Tuscarawas	55	54	4
Henry	9	10	1	Union	16	15	1
Highland	13	15	3	Van Wert	15	14	3
Hocking	7	7	3	Vinton	1	1	0
Holmes	10	10	5	Warren	14	12	2
Huron	31	33	1	Washington	37	36	6
Jackson	8	5	2	Wayne	62	60	4
Jefferson	83	89	6	Williams	24	23	1
Knox	39	34	5	Wood	42	41	3
Lake	134	132	8	Wyandot	8	8	1
Lawrence	24	23	3	Honorary	5	5	0
Licking	79	78	7	TOTAL	10,872	10,246	1,022

The Two Classes of Mankind

Presidential Address

Maurice F. Lieber, M.D., President, Ohio State Medical Association

(Delivered to the Association's House of Delegates, 1976 Annual Meeting, Cincinnati, May 9.)

These are troubled times . . . troubled times for all Americans and not just for medicine.

A time period measured in months, we have seen:

- * A United States President forced to resign that great office after being voted into office by the greatest plurality ever received by a presidential candidate.

- * A Vice-President resign in disgrace.

- * One of the most powerful members of the Congress publicly humiliated.

- * A United States Senator involved in the drowning of a young woman.

- * The world's greatest city brought to its knees by bankruptcy.

- * This great nation itself bowed under enormous debt, which threatened our fiscal responsibility and integrity around the entire world.

- * All America faces deep and serious troubles. We have an ailing economy. We are confronted with, but seem to want to do little about, a critical energy shortage. Americans' faith in and respect for their elected officials and lawmakers is at an all-time low. Indeed, we have a sick government.

I believe the troubles faced by American medicine are a reflection of the troubles all Americans face. We physicians are not responsible for these national conditions. Regrettably, there are some interests so antagonistic toward our profession that they publicly attempt to blame us for all these political, social, and economic ailments.

There is no logic in attempting to make medicine the whipping boy for those conditions . . . Unless it is the logic of Karl Marx that those who control the health, the education, and the welfare of a country indeed do control that country.

One of the most glaring symptoms of these troubled times is the headlong rush of ordinary, day-to-day living. We must run faster and faster just to stand still.



How many of us take the trouble these days to put our minds to these problems—medicine's problems, America's problems, and their interrelationship? How long has it been since you took time out to reflect, intelligently, analytically, and personally? Above all, each of us must personally pause to ponder, to reflect, to conclude.

In the First Century, Seneca told the Romans something that we absolutely must heed as we approach the 21st Century.

Seneca wrote: "Let no man presume to give advice to others that has not first given good counsel to himself."

I can't think of a better way to begin the annual deliberations of this House of Delegates than for you to "jog" through this film.

"Jogging" is defined as slow and easy running at a steady pace. In the past 12 months, your Ohio State Medical Association has sprinted more than it has jogged.

Also in the past twelve months, as your President, I have had much opportunity to reflect about this high office that you so graciously awarded me.

I subscribe to Teddy Roosevelt's contention that any presidency, whether it be of the United States, or a state medical association, should be a very important job, and should be held only by a very committed, a very forthright, and a very dedicated individual: a powerful job, and a person permitted power.

We know that the presidency of this Association is only for one year and not like the four-year term "T.R." was describing.

The effectiveness of the OSMA presidency can be reinforced as it can be negated in various ways—by staff people and by many persons. But, by and large, the President of this Association, in contradistinction to the President of the American Medical Association and other similar organizations, *is* the president of the association.

He is the Chairman of the Council. In the vernacular, he is "The Chairman of the Board." He is the Speaker of the House. He is the public spokesman as well as the interdisciplinary spokesman for the organization.

(Address continued page 430)



Presidential Address

He is a most involved and most personal president of and for the members. He is, for 12 months, a person of considerable authority. He can do many things, and that is as it should be. He *must* have this strength and authority if he is to function effectively.

However, having that degree of opportunity to act, he must be held to very, very strict *accountability*. Therefore, I do not propose to put my philosophy before such a learned group of physicians as is this House of Delegates. Instead, I would relate to you what OSMA has been facing in the past year, and what I have faced. I propose to talk to you about my stewardship.

One would have to be like an ostrich, with his head in the sand, to fail to see the juggernaut of laws and regulatory seizure of power that threatens American medicine. And we should take a lesson from the fact that the ostrich, when his head is in the sand, dangerously exposes his most sensitive parts.

Every physician must get his head out of the sand and concern himself with the deluge of state laws, federal laws, and administrative laws—that rain down on us daily and constantly. It is unthinkable that a doctor abandon his profession and his patients by pleading that he is “too busy with his practice” to get involved.

The Roman historian Tacitus was describing America today when he wrote, in the First Century, “When the state is most corrupt, then the laws are most multiplied.”

How modern and how true!

For decades, medical orators have relished the cry: “Medicine is at the crossroads.”

During the past year, medicine has been, rather than at the crossroads, caught in the middle of a high-speed, superhighway interchange.

Bearing down on us from one direction was the professional liability insurance crisis. Out of a fog from another direction came the Ohio Attorney General's suit against the Ohio Medical Indemnity Corporation and the OSMA.

Ohio's chiropractors now have their own licensing board, totally independent of the State Medical Board. A layman and a podiatrist have been made full members of the State Medical Board.



Coming around a blind curve was implementation of the National Health Resources and Development Act . . . Public Law 93-641.

Of course, there is that perennially lumbering tank truck—federalized health care.

About to disappear over the horizon is the medical manpower problem.

On the other hand, national surveys continue to show that physicians enjoy public confidence greater than any other profession or institution. But I must emphasize that confidence alone does not alter the shape of things to come. We are *not* the giants of yesteryear. Gone is the beloved but somewhat helpless “old doc” who strode into the sick room, exuding consolation and confidence but who could do so little really to cure. Now, we actually have means to technically keep people alive from the neck down even if they are dead from the neck up. We are very likely to be sued for everything we own in this world if a patient—any patient or his family—isn't satisfied with the result of his treatment or the end result of his accident—if the outcome does not meet with his great expectations.



The demands on OSMA's time, our attention, and, above all, financial resources, have been almost unbelievable.

Without the nearly 100 percent dues increase that became effective January 1, 1975, the OSMA would have been financially crippled.

Right here and now, I want to pay tribute to the members of the Ohio State Medical Association. Almost to a man, they accepted the major dues increase without complaint or protest. They accepted the Council's conclusion and the decision of the House of Delegates that the dues increase was absolutely essential for OSMA to continue to represent them effectively. And similarly, I want to pay tribute to the dedicated OSMA Administrative Staff, and to our faithful Auxiliary. Surely, no OSMA President ever has had a more competent, more hard-working Council.

Much has transpired since this House last convened in the midst of a chaotic professional liability insurance problem.

Legislation so strongly sought by this Association was enacted—while not entirely in the form we would have preferred—by the Ohio General Assembly.

Ohio's Joint Underwriting Association was organized and is functioning.

We were able to ease considerably the crisis of those Ohio physicians unable to obtain or retain malpractice insurance.

I certainly want to emphasize that our malpractice problems still exist. However—and fortunately—short-range measures have given medicine more time to come up with lasting, long-range solutions.

Ohio was not alone in this crisis, to be sure. Many states planned varied solutions, some successful and some not successful.

Medicine does not need and does not want a federal solution. It is our experience that federal solutions tend to create more problems than they solve.

We owe a good deal of thanks to our friends . . . friends in the legislature, in the news media, in state government . . . and in the insurance industry, for their substantial support in our campaign. For that support, Ohio medicine is deeply grateful.

In a special letter to the membership April 21, we solicited from each member a \$100 contribution to finance a five-point program which the Task Force on Professional Liability has developed. This program includes: (1) a court docket survey to develop liability statistics, (2) research into the feasibility of an OSMA malpractice insurance company, (3) investigation of legal changes needed to enable physicians to file countersuits, (4) actuarial data with which OSMA may challenge premium rate increases, and (5) a comprehensive public information and education program.

The support of every OSMA member is critically necessary.

Again, the timeliness of our dues increase seems almost providential.

Dr. James Sammons, Executive Vice-President of the American Medical Association, has publicly described the National Health Resources and Development Act of 1974 as "the single, most potentially destructive piece of medical legislation ever enacted by Congress."



OSMA has attempted to alert all county medical societies to developments under this Act. Medical society involvement is absolutely essential. Unfortunately, not enough physicians realize that local health facilities and services will be controlled by an area, consumer-dominated, health systems agency engaged in a direct contract with the Secretary of Health, Education, and Welfare. The Secretary will, in turn, control the health systems agency.

There no longer will be a state government pass-through, as there has been in other federally supported programs.

State government will be involved, but only in a somewhat advisory-consultative capacity.

The better you keep OSMA informed, the better OSMA can carry your questions and concerns to Washington.

Meanwhile, I hope the AMA will carry out its intention of opposing this program as strongly as possible, even in the courts if necessary.

Speaking of the AMA, I can think of no dedicated physician more qualified to serve as president of that organization than Ohio's own John Budd. We will nominate Dr. Budd for the office of President-Elect of the AMA next month at the Annual Convention, and we certainly intend to see that he is elected.

Moving on, we have that perennial crab grass wrongly referred to as national health insurance.

The dire predictions of health chaos made 15 years ago by government medicine advocates have failed to materialize. In fact, Americans are better cared for medically, more disease free and enjoying a greater life expectancy *now* than at any time in our history.

This is medicine's Bicentennial gift to this greatest of nations.

In 1940, the infant mortality rate in America was 47 per 1,000 live births. In 1975, it was 16.1 per 1,000.

In 1900, only 41 percent—less than half—of the nation's newborns could be expected to reach age 65. By 1973, seventy-three percent of the newborns had a 65-years-plus life expectancy.

(Address continued page 432)

Presidential Address

In 1940, with slightly more than half of all births occurring in hospitals, nearly 9,000 American mothers died in childbirth. In 1973, there were fewer than 500 maternal deaths—and OSMA's continuing study, I am certain, has contributed significantly to that outstanding improvement.

In 1950, 2,729 American children died from tuberculosis, diphtheria, measles, and polio. In 1973, the death toll from those four diseases was 43 in the entire United States. It is hard to believe that some of you in this House are too young to remember those dreadful polio epidemics. All the world remembers Albert Sabin for what he did right here in Cincinnati.

Speaking of mass immunization, the OSMA is alert to the national influenza immunization program planned for September or October. Dr. John Ackerman, State Health Director, is working closely with the OSMA. An OSMA Past-President, Dr. Richard Meiling, represented us at the emergency meeting held in April at the U.S. Center for Disease Control in Atlanta. He also represents OSMA on Dr. Ackerman's Influenza Immunization Advisory Committee.

About 14,000 children in the United States died of influenza and pneumonia in 1930. By 1974, that number was reduced to 1,345, despite significant population increase.



Giant strides have been made in detection, treatment, and prevention of today's major killer diseases, such as heart disease, hypertension, and cancer.

At long last, Americans—and their government—are beginning to realize that the individual is just as responsible for preserving his health as is his physician. Americans are beginning to understand that they must play an active personal role in protecting their personal and family health.

Perhaps Washington may begin to realize that Americans *are* healthier, live longer, and live better today. These statistics I have given you are taken from *Health, United States, 1975*, a 600-page study by the Department of Health, Education, and Welfare.

Health care in America is a legitimate national issue. It is by no means perfect, as we physicians well know.

But the greatest effect on health improvement of Americans would come and should come through better living habits—saner eating, drinking, smoking, and exercise habits. This could do more for Americans' health than all the legislation in the world.

Herbert Klein, a noted American economist, an advisor to presidents, and a former member of the President's Council of Economic Advisers, recognizes these health improvement facts. Mr. Klein has concluded that "These facts do suggest that national health insurance is not the best way to improve the national health . . . And," Mr. Klein points out, "if that is the case, new taxes to finance such insurance are certainly not the best way to improve the *economy's* health."

While medicine still is accused of creating and controlling the shortage of physicians, I am happy to recognize: (1) a fantastic increase in the number of medical schools in the past ten years, and (2) a tremendous swing toward primary care on the part of medical school graduates. Here, again, OSMA had a significant role.

The AMA reports that the number of medical schools increased from 89 in 1965 to 114 in 1975, with 11 more in the planning or organizing stage.

Medical school enrollment increased 70 percent in ten years.

Five years ago, the AMA said it would be desirable for 50 percent of the annual graduates to enter primary care residencies. Last year, 58 percent of the total graduates did enter primary care residencies.

Despite this bright picture, Washington seems bent on enacting so-called "medical manpower" legislation to give H.E.W. control over medical school admissions and overall residencies by types, numbers, and locations.

Last February, *The Cincinnati Enquirer* editorially recognized the tremendous increases in medical schools and medical students and warned of the dangers of federal control of medical education. *The Enquirer* editorial noted that this expansion was accomplished while preserving, at the same time, medicine's high standards of academic excellence. The editorial concluded:

It should not, in reality, surprise anyone that medical education should respond to the laws of supply and demand to roughly the same extent as any other component in a free-market economy.

Those who have been arguing that only the hand of government can insure an adequate supply of medical practitioners where and when they're needed should take a second look at medicine's quiet revolution.

Our Continuing Medical Education Program is flourishing. We have presented CME Recognition Awards to 72 members in this, the first year of our awards. We are working closely with the AMA and with the State Medical Board. I would remind you that 150 accredited hours every three years are required for licensure in Ohio.

It is regrettable that, while medicine and friends of medicine were working diligently, quietly, and, above all, effectively to increase the number of American medical schools and the quality of medical education, we continue to suffer outrageous accusations . . . accusations that physicians, through the AMA, were deliberately holding



down the number of medical schools . . . and the number of medical students . . . to keep a "medical monopoly."

In this area, the Federal Trade Commission has threatened to file suit against the AMA, alleging an AMA monopoly. I can't think of anything more ridiculous.

In addition to more schools, physicians, their wives and their friends have, through the American Medical Association, Education and Research Foundation, created a \$56,195,488 loan fund for medical students, interns, and residents. This has been done as one of medicine's methods of meeting America's medical manpower needs . . . and it has been done without federal dollars.

There is, unfortunately, a negative development that I must report to you. There are powerful sources within and outside the AMA that are working unceasingly to destroy the AMA's federation concept. If successful, this also would destroy the AMA as a spokesman for grass roots medicine. Without those roots, can the AMA survive? Your Ohio State Medical Association, through its delegation to the AMA, has a strong role in opposing any such change in the County Society-OSMA-AMA structure. We are indebted to Dr. Richard L. Meiling for his leadership and total dedication in this campaign.

Our Bicentennial Year seems to be highlighted by the AMA's vastly strengthened role as the advocate for American medicine. The AMA's high profile has become very apparent . . . very successful . . . and very commendable . . . in the areas of Congressional testimony . . . the malpractice crisis nationally . . . and the AMA's unprecedented use of federal courts to challenge federal controls and federal invasion of the doctor-patient relationship.

The AMA, in 1975, successfully sued the U.S. Department of Health, Education, and Welfare over proposed utilization review regulations pertaining to hospital admissions. It currently is suing HEW over regulations that would interfere with both the physician's right and his ethical and medical responsibility to determine the drug his patient receives.

And pending is the AMA suit against the Health Resources and Development Act of 1975—the so-called "planning law."

The AMA's new ten-point statement in support of basic research has excited our medical investigators. I think Dr. Irvine H. Page, Cleveland's internationally

known physician and medical philosopher, best summarized the AMA's resurgent support of this most fundamental segment of our profession. Dr. Page has stated: "The ten-point program indicates the AMA's newly aroused concern for research, part of a renewal process that is invading the entire organizational structure. It is time for those who lacked faith in the AMA leadership to look again."

As this House of Delegates embarks on its solemn deliberations and decisions in this, the 200th year of our independent Republic, I will close by paraphrasing Dr. Page's very wise advice.

Consider the pressure and erosions confronting our profession from multiple sources . . . and weigh the strong and effective aggressive advocacy role displayed by the one national organization that can . . . and must . . . speak for all physicians.

It is indeed high time for all physicians, including those who lacked faith in the American Medical Association leadership, to look again.

It is high time, also, to consider that old Indian adage about walking in the other fellow's moccasins. I said at the beginning, that I did not propose to belabor you with my philosophy . . . However, I close by asking you to consider the philosophy of *others* which related to our profession in their times.

Rudyard Kipling, at the turn of the century, said, "There are only two classes of mankind in the world—doctors and patients."

And, a hundred years ago, Robert Louis Stevenson, near the end of a lifetime of suffering, said:

There are men and classes of men that stand above the common herd: The soldier, the sailor, and the shepherd not unfrequently; the artist rarely; rarer still, the clergyman; (but) the physician almost (always) as a rule. He is the flower (such as it is) of our civilization . . . Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what is more important, Herculean cheerfulness and courage."

My friends, we cannot live on public opinion surveys and polls, but we certainly can all believe in, and live by, these wonderful words.

I know I can. How about you?



(Annual Meeting continued page 434)

A Sense of Ending, A Sense of Beginning

George N. Bates, M.D.

(Inaugural remarks on the occasion of his installation as President of the Ohio State Medical Association at Cincinnati, Ohio, May 12, 1976.)



It is human nature to have a strong feeling of finality as we conclude this most successful Annual Meeting.

Ohio medicine does indeed face many problems. But we physicians are trained and dedicated to the concept of problem-solving: The problem of diagnosis . . . The selection of treatment . . . The responsibilities of prevention.

The proceedings of this House of Delegates are an outstanding example of problem-solving.

You have worked long and hard. You have wrestled with major decisions. You have charted this Association's programs for the coming year. I hope all of you will leave here with a feeling of "well done."

But I also ask you to leave here with a sense of a beginning rather than an ending.

We will begin immediately to carry out the charges and responsibilities we have assumed through this convention.

I hope you will return to your local colleagues with a personal pledge to inform them of these actions and decisions . . . I hope you will involve them in supporting and helping to accomplish what must be accomplished in the coming months.



I urge each of you to think of yourself as a delegate 365 days a year, and not just a "four-day delegate."

I can assure you that your officers and councilors will work diligently to carry out the responsibilities you have given us. We earnestly solicit your continued interest and support.

It is fitting that our Annual Meeting is held in the spring. Spring is a time of renewal, of regeneration, and of rebirth.

Therefore, it is in this spirit that I ask you to leave here not with a sense of ending but with a sense of beginning. Let us begin now.

Annual Report to the House of Delegates

MRS. ROBERT E. KRONE, President

Ohio State Medical Association Auxiliary

The Ohio State Medical Association Auxiliary, with a membership of 4,975, is similar in structure to the state medical organization. There are 51 organized counties grouped into 12 councilor districts with physicians' spouses in unorganized counties joining as members-at-large. Together with other states, we form the American Medical Association Auxiliary, 90,000 members nationwide.

Our goal as an Auxiliary is to cooperate with OSMA in its programs to improve the quality of life through health education and services. We extend your influence in the community through volunteer work. We enhance your public image. We are active in the struggle for survival against an ever-encroaching federal bureaucracy.

As your pocketbooks may well attest, we are fundraisers for many causes. You will hear more this evening about the American Medical Association Education and Research Foundation. Total amounts of money for the current fiscal year are still being compiled, but our per-capita contribution last year was \$15 per member. The sharing Christmas card effort alone has produced \$27,444 this year. Add to this all the auctions and benefits that you attend, the watches or other jewelry you buy, and the memorial donations. These are the sources of funds for assistance to medical education.

Equally impressive, and in addition, is the granting of loans and/or scholarships to various allied professionals. In 17 counties, a total of \$57,628 has been provided to assist students preparing themselves for careers in the health fields. In two counties new endowment and trust funds are being set up for future loan programs on a continuing basis.

Other monies are used by county auxiliaries for educational materials (books, magazines, films, pamphlets) in libraries and schools and to support such divergent community programs as meals for the elderly and a day care center for children of professional hospital employees.

We offer more than material assistance. In communities across the state, auxiliaries are active volunteers in schools, clinics, hospitals, and senior citizens centers. We work with various health agencies in providing a wide range of services.

Health education is a top priority. Within the schools, members provide resource materials, in-service training for teachers, assistance in curriculum review, and some volunteer teaching. Career information is offered to students through clubs, fairs, and tours. In the communities, a variety of programs and projects offer individuals and/or groups information on child abuse, VD, safety, the Heimlich maneuver, breast self-examination, available clinic and health services, and so forth.

Like other organizations these days, we are having financial problems. The cost of services to members is going up. We are submitting a request for a nominal



dues increase to our members at the House of Delegates meeting on Tuesday. We maintain a central office in Columbus for housing of association records and a meeting place for committees. A part-time executive secretary handles much of the routine mailing, records, and management details.

Monthly communiques from state to counties keep officers and board members in touch with Auxiliary affairs. A state magazine, *The Ohio Medical Auxiliary News*, is sent to every member four times a year with information about Auxiliary activities at all levels—county, state, and national. We sponsor workshops for leadership training and exchange of ideas and projects among counties, and we hold an Annual Convention in conjunction with that of OSMA.

The Day at the Legislature is a particularly valuable undertaking. This year 70 auxiliaries attended a briefing-dinner conducted by OSMA staff, sat in on committee hearings of House and Senate, hosted 58 legislators for luncheon, and attended floor sessions of the Legislature. This successful educational program was featured in the April issue of *The Ohio State Medical Journal*.

We value such coverage in your publication because we want you to know what we are doing. In the months ahead, your *Journal* editor plans a variety of news notes and/or feature items to keep you informed about the Auxiliary. We are providing material bimonthly for articles in the new tabloid newspaper *Your Doctor Reports*.

We exist as an organization because of you—we are your Auxiliary. We want and need your support. Doctor, is your spouse a member? If not, why not? If she is contributing her time in other valuable community groups or is employed, we still need her as a dues-paying member to help support our endeavors. Encourage her—or him—to join us. We can do more together.

(Annual Meeting continued page 436)

New Councilors and AMA Delegates & Alternates

Stewart B. Dunsker, M.D.

Elected OSMA Councilor from the First District is Stewart B. Dunsker, M.D., Cincinnati. Dr. Dunsker, a Diplomate of the American Board of Neurological Surgery, received his undergraduate degree from Harvard College and his medical degree from the University of Cincinnati College of Medicine. After interning at the University of Illinois Research and Education Hospital, he completed residencies at Cincinnati General Hospital and Barnes Hospital, St. Louis. Dr. Dunsker also served as Chief Resident, Instructor in Neurosurgery, and Fellow in Neurosurgery at Barnes Hospital.

Dr. Dunsker is Assistant Attending Neurosurgeon, Clinician in Neurosurgery, at the University of Cincinnati, and Assistant Director, Neurosurgical Resident Training Program, at Christ and Good Samaritan Hospitals, Cincinnati.

Dr. Dunsker is a member of the Congress of Neurological Surgeons, the American Association of Neurological Surgeons, and the Society of University Neurosurgeons. He is a Fellow in the American Association for the Surgery of Trauma and holds a Fellowship in the American College of Surgeons. He is on the editorial board of the medical journal *Spine*.

A member of his local, state, and national medical associations, Dr. Dunsker has served the Cincinnati Academy of Medicine as secretary, chairman and member of the Legislative Committee, and member of the Emergency Committee. He is also on the Regional Advisory Council and the Executive Committee of the Ohio Valley Regional Medical Program. He has been active in the Congress of Neurological Surgeons, currently serving on the Nominating Committee and as Chairman of the Registration Committee.

Dr. Dunsker is on the Active Staff of Bethesda Hospital; the Attending Staff of Christ Hospital; the Associate Attending Staff of Good Samaritan and Providence Hospitals; the Associate Staff of Children's, Jewish, Dearborn County (Indiana), and Cincinnati General Hospitals; the Consulting Staff of St. Elizabeth Hospital (Kentucky); the Consulting Associate Staff of St. Luke Hospital (Kentucky); the Consulting Staff in the Department of Surgery, with privileges in Neurosurgery, at St. Francis Hospital; and the Courtesy Medical and Dental Staff of Christian R. Holmes Hospital, all in Cincinnati unless noted.

Dr. Dunsker, who served in the U.S. Army, is married to the former Ellen L. Treiman; they have one daughter.

Alford C. Diller, M.D.

Alford C. Diller, M.D., Convoy, is the new Councilor from the Third District. After receiving his undergraduate degree from Bluffton College, Bluffton, Ohio, he attended the University of Chicago School of Medicine. Following graduation, Dr. Diller interned at Blodgett Memorial

Hospital, Grand Rapids, Michigan, and gained residency experience at Parkview Memorial Hospital, Fort Wayne, Indiana. Dr. Diller has been in Family Practice in Convoy since 1955.

Dr. Diller maintains membership in numerous professional societies: the American Academy of Family Physicians, the Ohio Academy of Science, the American Association for the Advancement of Science, the New York Academy of Science, and his local, state, and national medical associations. He is President of the Ohio Academy of Family Physicians, the Van Wert Medical Arts Corporation, and Medical Associates, Inc., as well as Coroner of Van Wert County and a Director of the Van Wert Chamber of Commerce.

Dr. Diller, a Diplomate of the American Board of Family Practice, has served as President of the Van Wert County Hospital Medical Staff three times. He initiated the Van Wert County Hospital Coronary Care Unit and Mobile Coronary Care Unit. He also helped establish the Tri-County Mental Health Clinic.

Dr. Diller, who served in the Hospital Corps of the U.S. Navy, is married to the former M. Jane Basinger; the couple has five children.

S. Baird Pfahl, M.D.

The Eleventh Councilor District elected as its Councilor S. Baird Pfahl, M.D., Sandusky. Dr. Pfahl received his undergraduate degree from Harvard University and his medical degree from the University of Pittsburgh. Subsequently, he interned at Western Pennsylvania Hospital and completed an ophthalmology residency at The Ohio State University Hospitals.

Dr. Pfahl was stationed at the U.S. Naval Hospital, Memphis, Tennessee, from 1963 to 1965. Since 1965, he has maintained a private practice in ophthalmology in Sandusky.

Dr. Pfahl lists among his professional organization affiliations: Delegate to the American Association of Ophthalmology, member of the Ohio Ophthalmological Society, Past-President of the Toledo Ophthalmological Society, and member of the Society for Contemporary Ophthalmology. He is also a member of the AMA, the OSMA, and the Erie County Medical Society.

Dr. Pfahl is a Diplomate of the American Board of Ophthalmology and a Fellow of the American Academy of Ophthalmology and Otolaryngology.

In addition, Dr. Pfahl is on the Active and Consulting Staff and the Board of Trustees and is Past Chief of Staff of Good Samaritan Hospital, Sandusky. He is also on the Consulting Staff of both Providence and Memorial Hospitals, Sandusky, and Bellevue Hospital, Bellevue.

Dr. Pfahl is married to the former Phyllis Bolman, and they have four sons.

(Editor's Note: A complete list of OSMA Officers and Councilors appears on page 368.)

Jerry L. Hammon, M.D.

One of two men newly elected to positions as Delegates to the AMA is Jerry L. Hammon, M.D., Dayton. Dr. Hammon, who received his undergraduate degree from Miami University, Oxford, graduated from The Ohio State University College of Medicine. Following internship at Miami Valley Hospital, Dr. Hammon went into General Practice in West Milton. In 1973, he left this practice to become Staff Physician at the Veterans Administration Center, Dayton.

Dr. Hammon is codeveloper of a special preceptorship program for The Ohio State University College of Medicine and the Miami County Medical Association. From 1965 to 1973, he was engaged in preceptorship training programs in Family Medicine for students of the University of Cincinnati and The Ohio State University medical schools. He is currently Assistant Clinical Professor in the Department of Family Practice at Wright State University School of Medicine.

Dr. Hammon, a member of his local, state, and national medical associations, has served as consultant to the Miami County Board of Health for 12 years. A board member of the Miami Valley Heart Association, Dr. Hammon twice served as president of the Miami County Chapter. He is a Past-President of the Miami County Medical Society and a member of the Board of Trustees of the society's Educational Foundation.

An Alternate Delegate to the AMA for six years, Dr. Hammon also has given his energies to OSMA Committees on Scientific Work, Rural Health, Judging of Scientific Exhibits, and Legislation. From 1968 to 1970, he was invited to participate in a Health Care Delivery Symposium at the request of the Secretary of Health, Education, and Welfare.

Dr. Hammon serves as school physician for the sports program at Union-West Milton. He is also a member of the Advisory Committee to Union Township Trustees and of the Board of Trustees of the Friends of Milton-Union Library Incorporated, of which he has been president; and he served as chairman of the Union Township Heart Association Fund Drive.

Jack Schreiber, M.D.

Also elected Delegate to the AMA is Jack Schreiber, M.D., Canfield. Dr. Schreiber received his undergraduate degree from Wittenberg University, where he served as president of the student body, and his medical degree from the University of Cincinnati College of Medicine. After interning at Youngstown Hospital, he served a two-year preceptorship with William Bunn, M.D., Vice-President of the American Heart Association. Upon completion of the preceptorship, he entered General Practice in Canfield.

Dr. Schreiber is well-known for his ability as an orator. He has been a member of the AMA Speakers

Bureau since 1961, giving 600 major talks in 26 states during this period. Dr. Schreiber was the originator and moderator of a weekly series called "Consultation" which was broadcast on both radio and television. He has received six recognitions from the Freedom's Foundation of Valley Forge, including three George Washington medals. Dr. Schreiber often uses his ability as a magician to highlight his speeches.

Dr. Schreiber lists among his professional affiliations memberships in his local, state, and national medical associations and the Academy of General Practice. He is a Past-President of the Mahoning County Medical Society.

Dr. Schreiber, who served with the United States Navy during World War II, is married to the former Alice Sartin. They have four children.

Theodore J. Castele, M.D.

Elected to the position of Alternate Delegate to the AMA is Theodore J. Castele, M.D., Fairview Park. A graduate of Western Reserve University and Western Reserve University School of Medicine, Dr. Castele interned at University Hospitals of Cleveland, where he also completed residency and fellowship training in radiology. He is a Diplomate of the American Board of Radiology and a Fellow of the American College of Radiology.

Dr. Castele is Chief of Staff and Director of Diagnostic Radiology at Lutheran Medical Center, Cleveland. He also is Assistant Clinical Professor of Radiology at Case Western Reserve University School of Medicine; Director of the Pollen Count for Lutheran Medical Center, the Cleveland Academy of Medicine, and the Cleveland Health Museum; and a team physician for the Cleveland Indians. A favorite avocation of Dr. Castele is his position as staff physician for WEWS TV-5. (See "Cleveland Academy Speaks to Community," *The Journal*, Volume 72, No. 3—March 1976.)

Dr. Castele has served as president of numerous organizations: the Academy of Medicine of Cleveland, the Physicians' Peer Review Organization, the Cleveland Radiological Society, the Case Western Reserve University Medical Alumni Association, and the Innominatum Medical Society. He has also been Chairman of the Board of the Lutheran Medical Center Medical Foundation.

Listed among his professional affiliations are the Ohio State Radiological Society, the Radiological Society of North America, the Eastern Radiological Society, and the Medical Advances Institute. He is a member of the Council of the American College of Radiology. Currently, Dr. Castele is a trustee on the boards of the Lutheran Medical Center, the Greater Cleveland Council of the Boy Scouts of America, Medical Mutual of Cleveland, the Community Dialysis Center, the Cleveland Health
(continued on page 438)

New Councilors & AMA Delegates and Alternates

Education Museum, the Medical Advances Institute, and the Physicians' Peer Review Organization.

Dr. Castele is married to the former Jean Willse, and they have seven children.

William J. Schrimpf, M.D.

Also elected Alternate Delegate to the AMA is William J. Schrimpf, M.D., Cincinnati. Dr. Schrimpf received his undergraduate degree from Xavier University, his medical degree from Loyola University Stritch School of Medicine, and his master of science in otolaryngology from the University of Pennsylvania.

Following internship at Good Samaritan Hospital, Cincinnati, Dr. Schrimpf served a residency at Brooke Army Hospital, San Antonio, and did post graduate work in otolaryngology at the University of Pennsylvania. He

then became Chief of the Department of Otolaryngology at Lackland Air Force Base Hospital in Texas.

Dr. Schrimpf is currently on the Executive Board of Good Samaritan Hospital, Cincinnati, and is a member of the OSMA Insurance Committee. He is active in the Cincinnati Academy of Medicine, serving as the Chairman of the Ad Hoc Committee on Malpractice and Chairman of the first Third Party Review Committee. Dr. Schrimpf was also on the Executive Board of Ohio Medical Indemnity, Inc. and is a Past-President of the Cincinnati Otolaryngological Society.

Dr. Schrimpf and his wife have twin sons who are medical students at the Loyola University Stritch School of Medicine.

(**Editor's Note:** A complete list of AMA Delegates and Alternate Delegates appears on page 445.)

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Auxiliary Holds Successful Annual Convention

Joy Meyers, OSMA Auxiliary President

The Auxiliary of the OSMA held its 36th Annual Convention concurrently with the OSMA Annual Meeting. A highlight of the meeting was the announcement that Ohio would enter the design of Mrs. Abdul F. Naji in the AMA Auxiliary seal contest. Mrs. Naji's seal was selected over 22 others submitted by spouses of Ohio physicians. Subsequently, her design was chosen by the national organization as one of nine finalists in the contest. The AMA Auxiliary Delegates voted on the seal selection at the Dallas convention.



Mrs. Sloan for eventual election to the national presidency, a position not held by an Ohioan for over ten years. In addition, Mrs. Robert Krone will be nominated for a position on the AMA Auxiliary Nominating Committee.

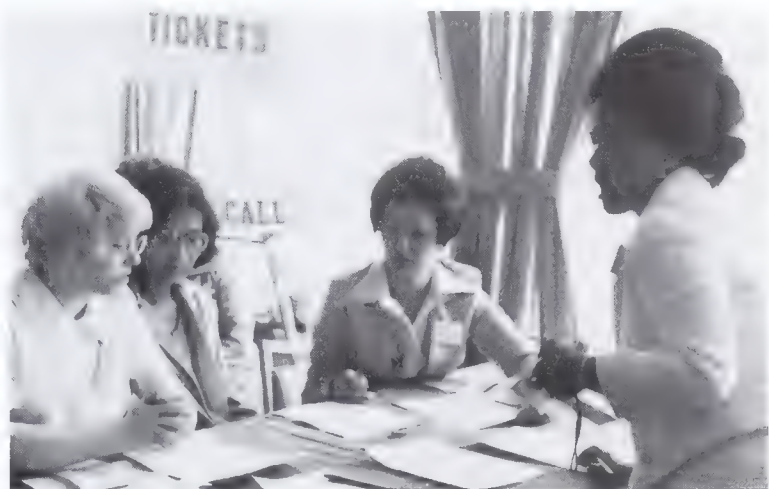
Newly elected Auxiliary officers include: Mrs. William Myers, President; Mrs. Albert May, President-Elect; Mrs. Emil Barrows, First Vice-President; Mrs. S. B. Pfahl, Second Vice-President; Mrs. K. V. Harshman, Third Vice-President; Mrs. H. D. Linquist, Secretary; Mrs. W. L. Damschroder, Treasurer; Mrs. Robert Krone, Past-President; Mrs. Ronald McLin, Director at Large; Mrs. Armin Melior, Director at Large; Mrs. William Mikita, Director at Large; Mrs. Karl Wieneke, Director at Large; Mrs. R. Stegemiller, District 1; Mrs. Robert Davies, District 2; Mrs. Thomas Allison, District 3; Mrs. John Van Der Veer, District 4; Mrs. Kent Brown, District 5; Mrs. W. F. Stevenson, District 6; Mrs. James Current, District 7; Mrs. Ralph Lewis, District 8; Mrs. Brooks Hurd, District 10; Mrs. James Curry, District 11; and Mrs. Edward C. Schott, District 12.

The Auxiliary emphasized its willingness to cooperate in efforts of the medical profession wherever possible. Assistance from the organization can be gained by contacting the president of the county auxiliary for local help or Mrs. William Myers, Auxiliary President, for state support.

The Auxiliary also made special mention of the success of its AMA-ERF campaign. Contributions for 1975 totaled \$21,067.38 more than in 1974, a 50.5 percent increase. The checks were presented to representatives of each of Ohio's medical schools at the OSMA House of Delegates (see "Proceedings of the House of Delegates" in this issue).

Two interesting programs are available for county auxiliary organizations. One is a presentation by Mrs. Richard Neubauer on "Breast Self-Examination," while the other is a talk by Robert Holcomb, OSMA Field Service Director, on "Implementation of Public Law 93-641."

Mrs. Malachi Sloan II will be installed as AMA Auxiliary Secretary for 1976-1977 at the Dallas convention. At that meeting, Ohio will nominate her for the National Board. The Ohio Auxiliary hopes to promote





Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential

status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.



Pharmaceutical Manufacturers Association
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OSMA Testimony on Medicaid Cost Containment Options (continued)

various provider groups. Through the use of such an intermediary, you would have better accounting procedures and more efficient management techniques than the State of Ohio can currently provide. As an example, this Committee has attempted for quite some time to obtain adequate data from the Department of Public Welfare which the Department has been hard pressed to provide in a timely manner. OSMA has frequently requested data that could not be provided. If the State of Ohio were to contract with a private fiscal intermediary, that contract could include provisions calling for the types of data which you—and providers—so desperately need. The Legislature then might know exactly where and how Ohio's tax dollars are being spent.

There are a number of other alternatives which the Committee is considering and which the Ohio State Medical Association thinks deserve comment.

Co-payments and/or deductible features seem very desirable from the viewpoint of the Ohio State Medical Association. Those Ohioans who are in need must get quality care and the mechanism must be developed to curb overutilization. Co-payments or deductibles would be one way to place responsibility on the recipient. If the Committee felt that co-payments might place an undue hardship on the recipient, you might consider a slight raise in Welfare benefits. The cost savings of co-payment-related reductions in overutilization could more than offset increased costs for these new benefits. This is a program that deserves exploration. Overutilization is a big issue that deserves a firm answer, and the provider is the least able to help you. Presently, Ohio physicians cannot tell you when a recipient is "doctor shopping."

In the utilization review area, regulations already are in place to provide many of the review alternatives which you are now considering. These could be appropriately implemented with very little cost for start-up. The federal government came into Ohio sometime ago for the purpose of developing a Model Medicaid Management Information System which was to include surveillance and utilization review techniques. What happened to all that effort and expenditure? Where are those programs?

Alternatives suggesting that the repeal of Ohio's laws prohibiting pharmacists from making substitutions in order to possibly save costs by substituting cheaper drugs could be more costly in the ultimate, since the patient might not respond to treatment as rapidly or as well. Also, substitutions would interfere with the physician/patient relationship which you so desperately wish to encourage. Substitution can result in malpractice suits. The official Ohio State Medical Association policy on this subject is that Ohio's physicians are responsible for the well-being of their patients and, therefore, Ohio's physicians expect to have prescriptions filled in exactly the manner specified by the physician.

Finally, I would be remiss if I did not discuss with

you the fact that the costs of providing the type of quality health care Ohio's patients expect is constantly going up. The current reimbursement formula utilized by the Medicaid program precludes any payments larger than that which are made by the Medicare program. The Medicare program payments do not include any factors for the costs of professional liability insurance—costs which have multiplied over the last two to three years. As an example, my own group's medical malpractice costs have jumped in the last three years from \$48,000 to \$290,000.

There is presently a proposal pending with the Ohio Department of Insurance to increase malpractice premiums another 145 percent. These costs are exorbitant and cannot, under any circumstances, simply be absorbed into our routine office budgets. We try very hard to keep our costs down but cannot do so in the face of these types of financial burdens.

Costs, whether malpractice or any other, must be borne by the patient or by the third party who has promised to pay his doctor bill. The Legislature must understand that the Medicaid recipient is treated by Ohio physicians just as any other consumer patient. Unless some recognition is made of these ever-increasing costs as a factor in providing quality health care, Ohio's physicians may very well be forced to cease their participation in the Medicaid program.

Ohio's doctors do not wish to be in a position where they must avoid Medicaid recipients. It is up to the Legislature to find and to implement alternatives that will *encourage*, not *discourage*, physician participation—at the same time, preserving quality of care.

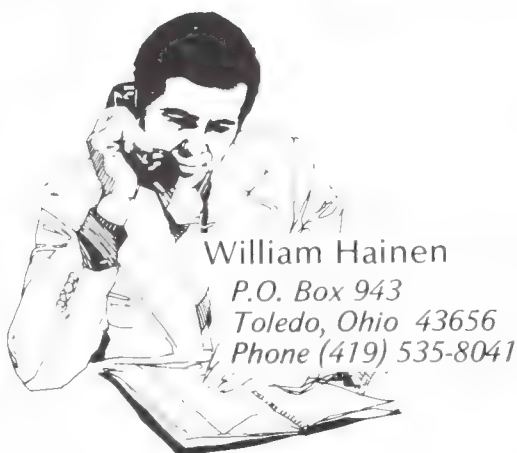
If government is going to establish public medical payments programs, then government must honor its obligation to be financially responsible for those programs.

I also want to emphasize as strongly as possible that government and medicine cannot guarantee the health of an individual who refuses to be responsible for protecting his health.

When a person smokes, drinks, overeats, eats the wrong foods, refuses to exercise—in short, refuses to recognize that he must accept some personal responsibility—then all the government dollars and all the physicians in America cannot prevent illness or even death.

To reduce demands, dollars, and disease, it is the opinion of the Ohio State Medical Association that a strong, sound, continuous, personal health education program among Medicaid recipients and their families, financed by the Department of Welfare, can become the most significant factor in reducing program expenditures, at the same time producing healthier and happier citizens.

I am very pleased to have had the opportunity to talk to you today. I would be glad to answer any questions that you might have.



William Hainen
P.O. Box 943
Toledo, Ohio 43656
Phone (419) 535-8041

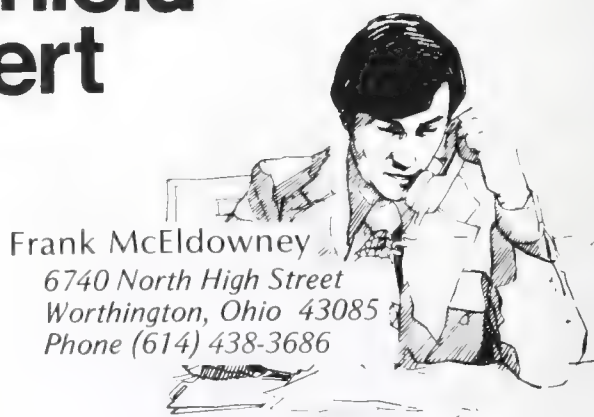


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HOSPITAL IN-SERVICE LICENSED (OHIO) PHYSICIANS urgently needed for a community hospital in southwest Cleveland area. Must have a minimum of two years approved U.S. residency. Salary competitive, paid malpractice, Blue Cross and other fringe benefits. Contact Dr. J. Morgan, 216/398-4141 ext. 388.

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AUGUST 1976
Volume 72, Number 8

THE OHIO Medical Journal

STATE



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WHY JOIN THE AMA?
INTERVIEW WITH JOHN H. BUDD, M.D.
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Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Medical Malpractice Suit Questionnaire

The OSMA Task Force on Professional Liability is currently developing accurate statistical data on the medical malpractice liability situation in Ohio. Reliable data *must* include information about all malpractice suits filed against Ohio physicians during the period *January 1970 through July 1976*.

The Task Force asks that you complete the following questionnaire indicating your experience with malpractice suits. This form appears in the August issues of both *The Journal* and the *OSMAgram*. Additional copies are available through *The Journal* office, 600 S. High Street, Columbus 43215. Telephone: 614/228-6971. Fill in a separate form for each suit.

Answers on this questionnaire will be **KEPT IN STRICTEST CONFIDENCE**. Please return the questionnaire no later than September 15, 1976.

Thank you for your assistance in developing this important professional liability data.

NAME _____ SPECIALTY _____

CITY _____ COUNTY _____

I have _____ NEVER been sued during the period *January 1970 through July 1976*.

_____ BEEN sued during that period as indicated below:

PLAINTIFF _____ PLAINTIFF'S ATTORNEY _____

(address) _____ (address) _____

DEFENSE ATTORNEY _____ (address) _____

DATE SUIT FILED _____ COUNTY COURT FILED IN _____

COURT DOCKET NUMBER _____ CAPTION _____

DISPOSITION OF CASE: _____ Went to Binding Arbitration

_____ Went to Trial (_____ Jury _____ Non-jury)

OUTCOME: _____ Verdict for Plaintiff _____ Verdict for Defendant

_____ Dismissed _____ Settled out of court

AWARD OR SETTLEMENT (if any) _____

INSURANCE COMPANY (if any) _____

DID INSURANCE COMPANY SETTLE WITHOUT YOUR PERMISSION? _____ Yes _____ No

ADDITIONAL COMMENTS: _____

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COVER: Left to right: AMA President Richard E. Palmer, M.D., and Mrs. Palmer with Irma and John H. Budd, M.D., AMA President-Elect, at the 125th Annual Convention of the AMA held in Dallas, Texas. (Photograph by Joe Fletcher of the AMA Staff)

Medical Board to Develop CME Relicensure Program

The Ohio State Medical Board has begun work on its Continuing Medical Education Certificate of Registration of Medical Licenses Program. Under new state legislative guidelines, any physician desiring Ohio registration of medical license must complete 150 hours of continuing medical education (CME) every three years. The first triennium runs from January 1, 1977 to December 31, 1979. Registration for physicians in 1977 does not require 150 hours of CME.

The Ohio State Medical Board will ask physicians to submit satisfactory evidence of completion of the 150 hours of CME. Recordkeeping methods and reporting procedures are currently under consideration. Physicians also will be asked to sign a statement that, under penalty of suspension of his or her license, he or she has completed the education requirement. This statement is being developed.

The Medical Board will recognize CME in two categories instead of the six categories originally proposed by the OSMA. (See "OSMA 1976 CME Physician Rec-

ognition Program," *The Journal*, Volume 72, No. 1, page 56.) The first category will be that specified as Category 1 in the OSMA Physician Recognition Program. A minimum of 60 hours during the three-year period must be in this category.

The Medical Board's second category will include OSMA Categories 2 through 6 as specified in the OSMA Physician Recognition Program. This will permit the physician to accumulate the remaining 90 hours in one or preferably a combination of the categories for the purpose of meeting the Medical Board's requirements.

The Medical Board will recognize the OSMA Commission on Medical Education's accreditation of hospitals/organizations that offer continuing medical education. (See "Ohio CME Accreditation Procedures," *The Journal*, Volume 72, No. 4, page 207, and "Accreditation Standards for CME Activities," *The Journal*, Volume 72, No. 6, page 374.)

The November 1976 issue of *The Journal* will carry extensive information on the continuing medical education requirements for the certificate of registration program. By that time, the Medical Board will have completed development of reporting procedures and other integral parts of the program. A monthly listing of Cate-

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

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RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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gory 1 CME offerings available to physicians will appear in *The Journal* beginning in November 1976.

Any physician desiring further information regarding CME requirements should contact his county medical society.

Northeastern Ohio Universities College of Medicine Begins Accreditation Process

Northeastern Ohio Universities College of Medicine has completed the first step in the formal accreditation process. On March 31, 1976, the College received a "Letter of Reasonable Assurance" (LRA) from the Liaison Committee on Undergraduate Medical Education of the Association of American Medical Colleges and the AMA.

In addition to approving the overall approach that has been taken in the development of the College, the LRA enables the Northeastern Ohio Universities College of Medicine to request and receive federal funds such as "start-up" grants and research contracts. Receipt of an LRA is a required step in the process of accrediting new medical schools.

An accrediting team will visit the College in January 1977 to review progress made in the intervening year. If satisfactory development has taken place, the College will

be recommended for provisional accreditation which will continue until the charter class has reached its final year (1981), at which time the College will be eligible for full accreditation.

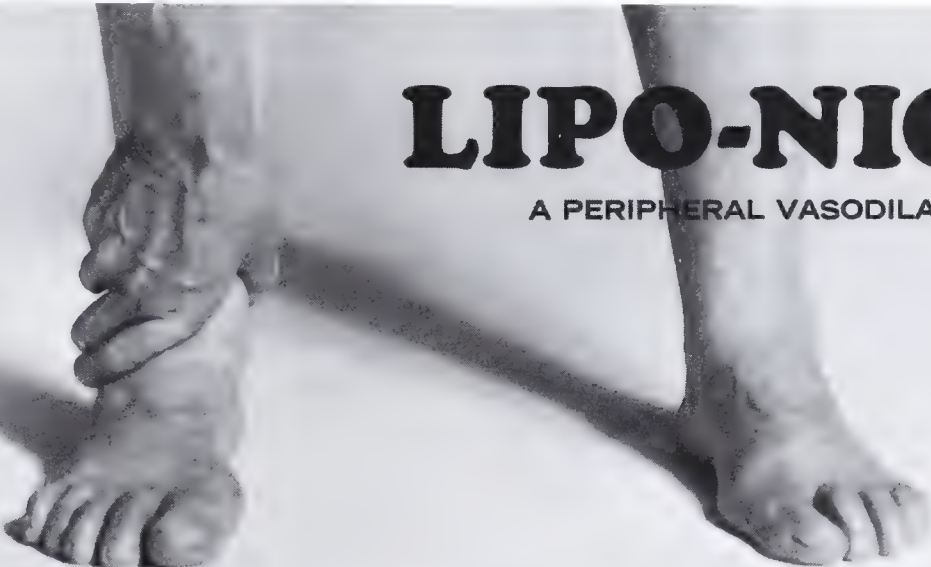
Diabetes Foundation Taking Fellowship Applications

The Juvenile Diabetes Foundation is currently accepting applications for postdoctoral fellowships for the funding year 1977-1978. Applications are available from Shel Sukoff, National Executive Director, Juvenile Diabetes Foundation, 23 E. 26th Street, New York, New York 10010. Telephone: 212/689-7868. Completed applications must be postmarked not later than September 10, 1976. Those being funded will be notified early in 1977, with funding to begin July 1, 1977.

Scientific Award Won by OSMA Maternal Health Exhibit

The OSMA Committee on Maternal and Neonatal Health sponsored an exhibit at the meeting of the American College of Gynecologists held in May in Dallas, *(continued on page 467)*

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Pyridoxine HCL (B-6) .. 10 mg.
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Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
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Report on 125th AMA Annual Convention

June 27 to July 1, 1976

The AMA House of Delegates meeting in Dallas, June 27 to July 1, 1976, commemorated our nation's bicentennial anniversary, the AMA's 125th Annual Convention, and the 75th Annual Meeting of the House of Delegates. The Ohio Delegation herein reports the highlights of action taken by the AMA House of Delegates.

Ohio Physicians Honored

John H. Budd, M.D., Cleveland, was elected President-Elect of the AMA. The Ohio Delegation, under the joint direction of Chairman P. John Robechek, M.D., and Cochairman and OSMA President George N. Bates, M.D., conducted an exemplary campaign in support of John H. Budd, M.D. The efforts of many spelled success at the polls. Direct campaign coordination was the responsibility of Chairman of the Campaign Committee Oscar W. Clark, M.D.; B. Leslie Huffman, M.D.; W. J. Lewis, M.D.; and Jerry J. Campbell of the OSMA Staff.



Left to right: President of the American Association of Medical Assistants Laura L. Lockhart and John H. Budd, M.D. (Photograph by Joe Fletcher of the AMA Staff.)

Ray Gifford, M.D., Cleveland, was elected member of the new Council on Scientific Affairs (term ending 1978).

Richard T. F. Schmidt, M.D., Cincinnati, was elected member of the new Council on Scientific Affairs (term ending 1977).

Harry Goldblatt, M.D., Cleveland, was selected by the AMA Board of Trustees to receive the 1976 Scientific Award. Dr. Goldblatt is world-renowned for his pioneer research concerning high blood pressure. In 1974, the World Health Organization named Goldblatt units as the international standard for human renin. A year earlier, Dr. Goldblatt was named to the National Academy of Sciences.

Dr. Goldblatt is Professor Emeritus of Experimental Pathology at Case Western Reserve University. He is also Director of the Louis D. Beaumont Memorial Research Laboratories at Mount Sinai Hospital, Cleveland.

House Considers Ohio Resolutions

The OSMA Submitted two resolutions for consideration by the AMA House of Delegates.

Preservation of Direct Billing

WHEREAS, The American Medical Association has previously adopted a policy that defends the physician's right to bill his patient for services rendered, and

WHEREAS, A recent bill (S. 3205) introduced in the U.S. Senate may attempt to interfere with the right of a physician to directly bill a patient who may be covered under a governmental program, **THEREFORE, BE IT**

RESOLVED, That physicians should not be forced by law or regulations to accept assignment as payment in full from third party carriers, and that physicians should be encouraged to study carefully the implications of voluntarily accepting assignment, and **BE IT FURTHER**

RESOLVED, That laws or regulations which place limitations on reimbursement of physicians be deemed improper and discriminatory, and **BE IT FURTHER**

RESOLVED, That this House of Delegates reaffirm the policy that physicians have the right to bill patients directly for services rendered regardless of any third party carrier, either private or governmental with whom the patient is contracted, and **BE IT FURTHER**

RESOLVED, That a copy of this resolution be sent to each U.S. Senator and Representative.

This resolution was considered by Reference Committee B (Legislation) in conjunction with three other resolutions: #18 — "Medicare-Medicaid Administrative and Reimbursement Reform Act (S. 3205)," #47 — "Physician Reimbursement Under Medicare-Medicaid," and #96 — "The Medicare and Medicaid Administrative Reform Act (S. 3205)." The Committee reported to the AMA House of Delegates as follows:

These resolutions are concerned with provisions of S. 3205 — Medicare-Medicaid Administrative and Reimbursement Reform Act, pending in the Congress. The resolutions ask that the Association: Actively oppose those sections which deny the physician the right of free contract, the right to be self-employed and which discriminate against hospital associated physicians (res. 18); state its opposition to principles of medical practice and work for the rejection of this legislation and, should it be enacted, challenge it in the courts (Res. 47); continue to support the physician's right to choose the method of reimbursement and to make this support known to each member of Congress (Res. 63); and seek removal or amendment of those portions of the bill which are harmful to physicians and to the physician-patient relationship (Res. 96).

Your Committee received testimony reflecting strong opposition to S. 3205. Your Committee concurs in the condemnation of those provisions which infringe upon freedom of contract,



Left to right: Richard L. Fulton, M.D., and Mrs. Fulton with Marcia Smith and her father, Robert N. Smith, M.D. (Photograph by Harry K. Hines, M.D.)

upon the right of direct billing or upon the right to be self-employed, as well as those provisions discriminating against "hospital associated" physicians.

Your Committee has been advised that the Council on Legislation has thoroughly examined this bill in its entirety and that the Board of Trustees has approved the detailed recommendations of the Council concerning this lengthy and complex bill. Your Committee is satisfied that this Association activity will fully reflect and incorporate the concerns in the resolutions and in the comments presented in testimony at the hearing. The Committee is also apprised that, although many provisions are totally objectionable, some provisions of the bill are worthy of support. Testimony expected to be given when hearings are held will present the various positions recommended on the many provisions in the bill.

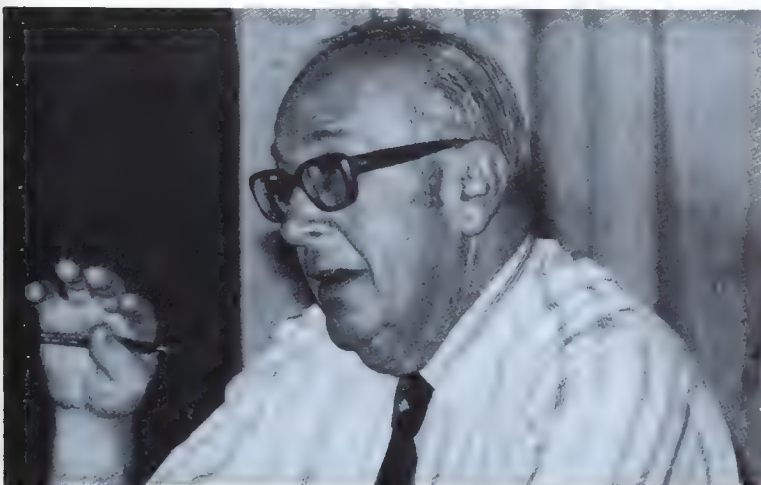
Your Committee is of the opinion that the intent of the Resolutions would be carried out in the following Substitute Resolution:

RESOLVED, that S. 3205 in its present form should not be adopted by the Congress, and that the American Medical Association strive to remove or amend those sections of the bill which are not in the interest of the public and the profession, and to support those provisions which it finds are constructive and beneficial;

RESOLVED, that the Board of Trustees take appropriate safeguards to protect the interests of the public and the profession from unwarranted and unjustified intrusions in the provision of high quality health care in government programs.

RECOMMENDATION: Mr. Speaker, your Reference Committee recommends that Substitute Resolution 18 be adopted in lieu of Resolutions 18, 47, 63 and 96, and be referred to the Board of Trustees for appropriate action.

The Substitute Resolution was adopted.



P. John Robeck, M.D., Ohio AMA Delegation Chairman. (Photograph by Robert G. Thomas, M.D.)

The OSMA also submitted the following resolution which was heard by Reference Committee A (Insurance and Medical Service):

Uniform Hospital Discharge Abstract

WHEREAS, Notice of proposed HEW implementation for a Uniform Hospital Discharge Abstract appears in the January 16, 1976 *Federal Register*, and

WHEREAS, The American Medical Association has gone on record opposing implementation of the HEW Uniform Hospital Discharge Abstract as promulgated, **THEREFORE BE IT**

RESOLVED, That the AMA be commended for its strong position filed in opposition to the implementation of the Uniform Hospital Discharge Abstract, and **BE IT FURTHER**

RESOLVED, That the AMA encourage state and local medical societies to not only be aware of but to register their complaints to HEW when proposals such as these are promulgated.

The Committee considered this resolution along with "Report E of the Board of Trustees: Confidentiality of the Uniform Health Data Abstract (Resolution 12, C-75)" and resolutions entitled #3 — "Opposition to Use of a Social Security Number as a Universal Identification," #24 — "Social Security Identification Numbers," #94 — "Use of Social Security Numbers as a Universal Identifier System," and #6 — "Opposition to Identifying Numbers for Physicians." The Committee made the following report:

Board of Trustees Report E is a progress report on AMA efforts to seek deletion, for purposes of confidentiality, of the request for patient and physician names and their respective Social Security numbers from the Uniform Hospital Discharge Abstracts (UHDA) submitted by Medicare intermediaries. Such efforts were called for by Resolution 12 (C-75), and Report E indicates that the Department of HEW is currently reexamining its position on inclusion of such information as the result of strong objections it has received from the Association and other groups. Resolutions 3, 6, 24 and 94 all call for strong opposition by the Association to the use of the Social Security number as a universal numbering identifier on any hospital or medical records. Resolution 64 commends AMA's efforts to secure deletion of this information from the UHDA, and would have AMA encourage state and local medical societies to similarly oppose such undesirable proposals.

Your Reference Committee believes that Resolution 6 best expresses the intent of Resolutions 3, 24 and 94.

RECOMMENDATIONS:

Mr. Speaker, your Reference Committee recommends that **Board of Trustees Report E be filed.**

Mr. Speaker, your Reference Committee recommends that **Resolution 64 be adopted.**

Mr. Speaker, your Reference Committee recommends that **Resolution 6 be adopted in lieu of Resolutions 3, 24 and 94.**

All recommendations were adopted with Resolution 6 first being amended.

The House of Delegates also passed the following Memorial Resolution in honor of Ohioan Walter H. Maloney, M.D.:

WHEREAS, Walter H. Maloney, M.D., has been a member of the Academy of Medicine of Cleveland, the Ohio State Medical Association, and the American Medical Association since 1958, and

(continued on page 463)

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INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to



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Complete literature available on request from Professional Services Dept. PML



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AMA Report (continued)

WHEREAS, Dr. Maloney served as President of the American Bronchoesophagological Association, Secretary of the Section on Otology, Laryngology, and Rhinology of the AMA, and was a Delegate from the Otorhinolaryngology section to this House of Delegates, and

WHEREAS, Dr. Maloney was an exemplary practitioner and teacher, having been Director of the Division of Otology at University Hospitals and Associate Professor of Otolaryngology at Case Western Reserve University and Chief Consultant at the Veterans Hospital, in which positions he contributed so much to the profession he loved, and

WHEREAS, Dr. Maloney passed away on May 16 of this year,
THEREFORE BE IT

RESOLVED, That this House expresses its profound sense of loss at the passing of this fine physician, Walter H. Maloney, and that this resolution be spread upon the minutes of these proceedings and a copy of the resolution be sent with deepest sympathy to his family.



Left to right: W. J. Lewis, M.D.; Jerry J. Campbell, OSMA Staff; John H. Budd, M.D. (Photo by Robert G. Thomas, M.D.)

Legislative Action

In addition to these resolutions, the House of Delegates took the following legislative action:

(1) Recommended a change in the Constitution to abolish the position of AMA Vice-President. This requires final action at the House of Delegates Clinical Meeting in Philadelphia in November 1976. Should the House act to confirm this proposal, it will be effective July 1, 1977.

(2) Established all Councils as AMA Councils (eliminating Councils of the House and Councils of the Board).

(3) Established three-year terms for members of the following councils with eligibility for three successive terms: Constitution and Bylaws, Medical Service, Medical Education, Scientific Affairs, Continuing Physician Education and Legislation.

This action was presented as a means of providing uniformity and accountability, the latter being stressed as of considerable importance.

The Judicial Council will retain its status quo, namely, members will be proposed by the AMA President

and confirmed (elected) by the House. Terms will be five years subject to "reproposal and reconfirmation for a second five-year term. (Accountability did not seem to be of similar concern to the House as had been the issue with members of the other councils.)

The Council on Long Range Planning and Development retains its status quo with members being *appointed* equally by the Speaker of the House and the Board of Trustees.

(4) Bylaw Amendments were approved to remove from the House of Delegates the "authority of the legislative and policy-making body of the AMA." Effective July 1, 1976, the Bylaws are amended "to assure complete independence of the 'Executive,' 'Legislative,' and 'Judicial' branches of the Association.

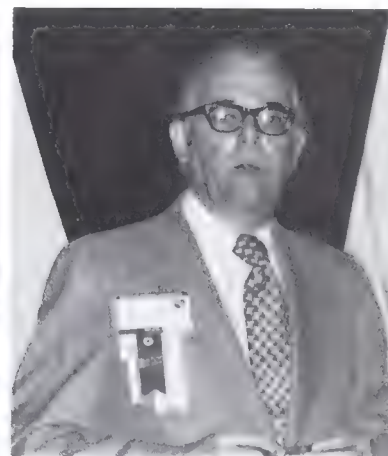
Henceforth, voting members of the Board of Trustees may not be delegates or alternate delegates or serve as members of councils or committees except when specifically provided for in the Bylaws. A member of the Judicial Council may not serve as a delegate or alternate delegate, may not be a member of any other council or committee, and may not be a general officer of the Association.

(5) The Council on Scientific Affairs was established, as was the Council of Continuing Physician Education.

(6) All Committees of Council must be approved by the Board of Trustees, and a two-year limitation will be placed on the committee's existence. The Board may extend the charter of the committee at the end of each two-year period. (This is to provide accountability and fiscal responsibility.)

(7) Established the "Resident Physician's Section." Resident members are identified as members of the Association who are serving in training programs approved by the Association.

(8) Slotted positions are provided for medical student members of the AMA, resident physician members of the AMA, and all councils except the Judicial Council. Likewise, one slotted position for a practicing physician who does not hold a salaried position with a university or associated hospital is provided for in the Council on Medical Education.



Left: Richard L. Meiling, M.D. Right: Oscar W. Clarke, M.D. (Photographs by Robert G. Thomas, M.D.)

(continued on page 464)

AMA Report *(continued)*

(9) Continued support of HR 6222 and for provisions of both basic and catastrophic insurance coverage where such is needed. (H.R. 6222, often referred to as the "AMA Bill on National Health Insurance," will expire with the present Congress in December 1976. New legislation must be proposed for consideration in the new Congress beginning in January 1977.)

(10) Did not endorse collective bargaining through trade unionism affecting interns, residents, or other physicians.

(11) Opposed the mandatory delegation of the diagnosis and treatment of the private patient primarily to housestaff physicians in teaching hospitals or in any other hospital setting.

Refusal of a physician to delegate the care of his private patients to members of the housestaff shall not be grounds for reduction or termination of his privileges.

There shall be one physician responsible for the care of the patient in the hospital, and this physician shall be the patient's own private physician.

The Joint Commission on the Accreditation of Hospitals should, through its accreditation standards, maintain the right of free choice by a patient to have the care provided in the hospital ordered and controlled by his private physician.

(This AMA position has been officially sent to both the HEW [Medicare and Medicaid patients] and to the Joint Commission on Accreditation of Hospitals.)

(12) Encouraged physicians and their families and their patients and their families to refrain from viewing television programs with episodes of violence (Violence on TV: An Environmental Hazard).

(13) Urged physicians to continue to act as non-smoking examples to the public and to discourage the presentation of visual materials which depict smoking as the norm of American culture. (The Dallas sessions of the House of Delegates were marked by the almost total absence of the use of tobacco by the Delegates.)

(14) Commended the Illinois, California, and Florida State Medical Associations for their support of physicians initiating countersuits against lawyers and plaintiffs who file nonmeritorious, professional liability lawsuits and the other state medical societies who give appropriate assistance to physicians in initiating and pursuing carefully selected, meritorious countersuits.

Resolutions for Next Meeting of the AMA House of Delegates

If a physician or county society has resolutions to propose before the convening of the AMA House of Delegates, Philadelphia, November 27, 1976, please forward them to OSMA Headquarters, 600 South High Street, Columbus, Ohio 43215, Attention: Jerry J. Campbell. Resolutions should be submitted as early as possible but not later than September 15, 1976.

Additional information about the Dallas meeting may be obtained by contacting Mr. Campbell.

Delegates to the AMA: Oscar W. Clarke, M.D.; Henry A. Crawford, M.D.; Harry K. Hines, M.D.; W. J. Lewis, M.D.; Richard L. Meiling, M.D.; H. William Porterfield, M.D.; P. John Robechek, M.D.; Robert N. Smith, M.D.; and Robert E. Tschantz, M.D.

Alternate Delegates to the AMA: John E. Albers, M.D.; George N. Bates, M.D.; Dwight L. Becker, M.D.; Richard L. Fulton, M.D.; John J. Gaughan, M.D.; Jerry L. Hammon, M.D.; B. Leslie Huffman, Jr., M.D.; Jack Schreiber, M.D.; and Robert G. Thomas, M.D.



Seated left to right: OSMA President George N. Bates, M.D.; AMA President-Elect John H. Budd, M.D.; and AMA Delegation Chairman P. John Robechek, M.D. Standing left to right, Members of the OSMA Council: Thomas W. Morgan, MD.; Secretary-Treasurer Robert G. Thomas, M.D.; William Dorner, Jr., M.D.; C. Edward Pichette, M.D.; Robert E. Rinderknecht, M.D.; Stephen P. Hogg, M.D.; Immediate Past-President Maurice F. Lieber, M.D.; C. Douglas Ford, M.D.; John J. Gaughan, M.D.; President-Elect William M. Wells, M.D.; Alford C. Diller, M.D.; and J. Hutchison Williams, M.D. Not pictured: Richard E. Hartle, M.D.; W. J. Lewis, M.D.; and S. Baird Pfahl, Jr., M.D.

Why Join the AMA?

An Interview with John H. Budd, M.D.
Ohio Physician and AMA President-Elect

"The AMA," stated John H. Budd, M.D., Cleveland physician and AMA President-Elect, "is everyone of us who is a member. It needs input from all physicians and the many various medical organizations."

Dr. Budd, a firm believer in the worth of the AMA to every physician, continued by stating that each physician must be a missionary for the profession. Physicians, he noted, are often so busy that they overlook advantages to the profession for which the AMA has worked long and hard. These same physicians, Dr. Budd feels, ought to take time to reflect upon the achievements the AMA has won on their behalf.

Dr. Budd indicated that membership in the AMA must be made so attractive and valuable that a physician cannot turn it down. Obviously in this day and age, there is increasing need for an organization that functions as the doctor's advocate: standing up for his rights, his point-of-view, and his security.

The AMA has been — and will continue to be — such an advocate. For instance, AMA effort has been an effective force in slowing the progress of Senator Edward M. Kennedy's health care legislation. The AMA has continued to point out the disadvantages of this program, paramount among them being the plan's cost. The cost factor has been increasingly recognized over recent months as has been vividly illustrated by the fact that the enthusiasm of such previous believers as the Teamsters Union and John Tunney of California has cooled.

Another giant stride made by the AMA is in the area of retirement savings. The AMA succeeded in instituting the Keogh Plan under which physicians may defer tax payments on up to \$7,500 of annual earnings.

Dr. Budd noted that the tax saved by participating in one year of this plan would pay over ten years' worth of AMA dues.

One of AMA's most spectacular victories was its win in the Utilization Review suit. This suit was instituted on the basis that the regulations issued would violate the Medicare law which prohibits federal intervention in the private practice of medicine. A preliminary injunction was granted and was upheld on appeal. The patient, of course, is the ultimate beneficiary of AMA's victory. New regulations have been proposed. Comment has been invited and submitted. At the present time, there are no regulations in force.

The AMA also opposed the Manpower Bill of 1975. This bill would have placed federal control on the distribution of medical residencies, both by geographic area and specialty. In addition, the bill had a student "pay-back" clause which required medical students to reimburse the federal government for the difference between tuition and the actual cost of the education.

A good example of AMA support in a local problem

occurred in Huron, South Dakota, when a hospital board of trustees unilaterally amended the hospital bylaws without staff input. The state medical association requested and received AMA legal support at the trial, and the law suit was decided in favor of the medical staff.

Currently, the AMA has entered the suit filed by the State of North Carolina against the Health Planning and Resources Development Act, which has been described by James H. Sammons, M.D., AMA Executive Vice-President, as "the single, most potentially destructive piece of medical legislation ever enacted by Congress."

In order to better serve physicians, the AMA recently established a Department of Negotiations which conducts courses and seminars designed to improve skills in the art of bargaining and the capability to respond to the needs of the federation and its members in negotiating with hospitals, government agencies, third parties, consumer organizations, and so forth. Dr. Budd noted that this department illustrates the ability of the AMA to do for the medical profession all that unions profess to offer, with the single exception of the strike.

The AMA is also of tremendous importance in the training and continuing education of physicians. In its capacity to accredit medical schools, residencies, hospitals, and CME programs, the AMA meets an important responsibility for maintaining the quality of medical education and health care. In addition, through its AMA-ERF program, the AMA has been directly responsible for providing the education dollars to many current and future physicians. In less than 15 years, the AMA has guaranteed 60,000 loans totaling \$70 million. Since 1951, AMA-ERF has granted more than \$26 million to approved medical schools.

Dr. Budd concluded his thoughts on the importance of the AMA in the life of every physician by stating: "The AMA has the size, experience, resources, personnel, credibility, and access necessary to be an effective advocate on behalf of medicine."

Ohio's John H. Budd, M.D., the next President of the AMA, intends that the AMA be responsive to the needs of the individual physician. To this end, he will strive to see that all letters from members are answered and to the extent possible, personally. He will spend a great deal of time traveling around the nation speaking in support of the physician and his profession.

John Budd cannot contribute to the betterment of the medical profession without the backing and input of all physicians. Are not the recent accomplishments of the AMA reason enough to support the organization by joining its membership ranks? If you are not an AMA member, contact your county medical society for application information. The AMA's voice and influence can only be as strong as a supporting membership chooses to make it.

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Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

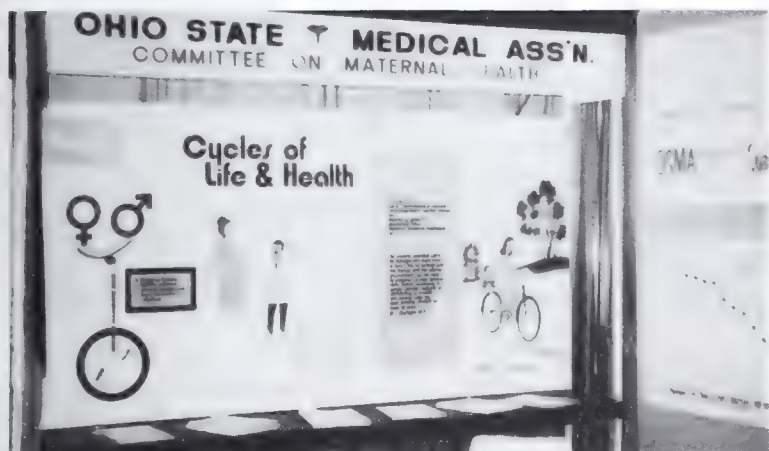
Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Texas. Anthony Ruppertsberg, Jr., M.D., committee chairman, took the display which demonstrates results achieved through the Ohio Maternal Mortality Study. This study covers the 88 Ohio counties and has operated continuously for the past 20 years. The exhibit specifically compares statistics of the years 1955 and 1973, revealing a marked decrease in maternal deaths. "Our obstetrics is good—Let's make it better" leads the observer to standard modalities of "ideal" care during pregnancy, labor and delivery, and the puerperium through "cycles of life," portrayed in cartoon fashion. The American College of Gynecologists honored the exhibit with a scientific award.



(Photo by Anthony Ruppertsberg, Jr., M.D.)

OSMA Awards Thomas E. Rardin Family Practice Scholarships

The OSMA has selected G. William Courtright II, Mount Vernon, and Elizabeth J. Schreiner, Hinckley, as the recipients of its 1976 Thomas E. Rardin Family Practice Scholarships. This year marked the 28th annual awarding of \$2,000 scholarships which are a part of OSMA's continuous activities to stimulate young men and women of Ohio to enter the medical profession, with emphasis on their becoming family physicians serving Ohio residents.



Left to right: Robert R. C. Buchan, M.D., and Leonard S. Pritchard, M.D., judges on Thomas E. Rardin Family Practice Scholarship Subcommittee.

The winning candidates were selected in competition judged on the basis of character, integrity, intelligence, mature personality, need, interest in community life, leadership, scholastic ability, and interest in becoming a family physician.

Following graduation from Mount Vernon High School, Mr. Courtright attended Massachusetts Institute of Technology and recently completed his premedical studies there. Along with a scholastic ranking of 4.5 out of a possible 5.0 at MIT, Mr. Courtright was also a member of the varsity basketball team for two years. He will enter Case Western Reserve University School of Medicine, Cleveland, this fall.

Ms. Schreiner was graduated first in her class at Highland High School, Medina. She recently completed her premedical training at Rensselaer Polytechnic Institute, Troy, New York, and will enter the University of Cincinnati College of Medicine in September.

As of this fall, there will be eight students receiving OSMA scholarships in medical schools.



Left to right: Jasper M. Hedges, M.D.; Robert E. Reiheld, M.D.; and E. D. Mattmiller, M.D., scholarship judges.

New Medical Professorship at OSU

The Ohio State University College of Medicine has established the Harry C. and Mary Elizabeth Powelson Professorship to provide tutorial services for worthy and needy medical students. The professorship was made possible by a \$233,885.60 bequest from the estate of the late Dr. Powelson. A former fellow of the Mayo Clinic, Dr. Powelson operated the Powelson Clinic in Zanesville from 1930 until his death in 1972. He received both his undergraduate and medical degrees from Ohio State.

(continued on page 471)

Crossing County Lines

Mahoning County Hosts Speaker of AMA House of Delegates

Guest speaker at the May meeting of the Mahoning County Medical Society was Tom E. Nesbitt, M.D., Speaker of the AMA House of Delegates. Dr. Nesbitt, who has also served the AMA as a member of the Committee on Private Practice, the Speakers Bureau on National Health Insurance, and several reference committees, practices urology in Nashville, Tennessee. A past president of the Tennessee State Medical Association, Dr. Nesbitt has been President of the American Association of Clinical Urologists. Currently, he is Vice-Chairman of the Constitution and ByLaws Committee and the Professional Relations Committee of the American Urological Association.



Left to right: Mahoning County Medical Society President William E. Sovik, M.D., and Tom E. Nesbitt, M.D.

Dr. Nesbitt noted that today's physicians are living in an interesting time during which the profession has been the subject of intense criticism, and suggested that solutions to problems are to be found by meeting the problems rationally. Tom Nesbitt is a firm believer that all physicians have the responsibility to dedicate part of their lives to the betterment of the profession.

He discussed changes in the AMA that have occurred in the last two years. One major change involved is the cash-flow problem. The staff was cut by approximately 200 and expenditures restricted. Because of this, priorities had to be carefully delineated resulting in the AMA becoming more activist in nature.

In 1975, the AMA budget totalled \$37½ million; in 1976, this amount rose to \$43 million. This money is to provide for all functions of the scientific, educational, and informational organization. Half of the budget is directed



Jack Schreiber, M.D., introduces Dr. Nesbitt with the aid of one of his many magic tricks.

at improving the quality of medical care. Of this amount, 35 percent is allotted to the AMA publications. Dr. Nesbitt noted that the *Journal of the American Medical Association* is the most highly regarded and widely read medical publication in the U.S.

Dr. Nesbitt stressed that the AMA is the only organization that can effectively deal with government, business, organized labor, and the like to promote the best interest of the physician and quality medical care. He emphasized that without the maximum support of all physicians, the AMA cannot adequately address all issues facing the medical profession today.



Left to right: Mahoning County Medical Society Executive Secretary Howard C. Rempes, Jr., and Mrs. and Dr. J. James Anderson, Mahoning County Medical Society Vice-President.

Cuyahoga County Medical Society Honors Many at Annual Meeting

The Annual Meeting of the Academy of Medicine of Cleveland was highlighted by the presentation of numerous awards to area physicians. William J. Gardner, M.D., a member of the Emeritus Staff of the Cleveland Clinic Foundation, received the Award of Distinguished Membership. According to the Bylaws of the Academy, this honor "may be granted to a doctor of medicine whom the Academy deems worthy of a special honor because of notable service to medicine or because of long activity in the interests of the Academy." It is the highest award conferred by the Academy.

Charles L. Hudson, M.D., Past-President of the AMA, the OSMA, and the Academy, was the recipient of a Special Award. This award is represented by a portrait of Dr. Hudson which will hang permanently in the office of the Academy.

Distinguished Service Awards were presented to two Past-Presidents of the Academy: Vincent T. LaMaida, M.D., and Julius Wolkin, M.D. Voted Clinician of the Year was Fernando Lim, M.D., a family practitioner.

Medical Mutual of Cleveland designated Alan R. Moritz, M.D., as the recipient of the Medical Mutual Honor Award in recognition of his contributions to the field of forensic pathology.

The meeting was also marked by the passing of the gavel from Frederick T. Suppes, M.D., to George P. Leicht, M.D. Other new Academy officers are President-Elect Edward G. Kilroy, M.D.; Vice-President John G. Poulos, M.D.; Secretary-Treasurer Steven Kovacs, M.D.



Above Top: (left to right) William E. Forsythe, M.D., Chairman of the Honors Committee of the Academy; Charles L. Hudson, M.D.; and John J. Gaughan, M.D., OSMA Fifth District Councilor, and Mrs. Gaughan. **Above Middle:** (left to right) Frederick T. Suppes, M.D., and George P. Leicht, M.D. **Above Lower:** (left to right) William E. Forsythe, M.D., and Fernando Lim, M.D. **Left:** (left to right) Edward C. Lechner, President of Medical Mutual of Cleveland, Inc., and Alan R. Moritz, M.D.

Am. Col. of Radiology Position on Mammographic Examinations

Mammography has proven to be the most effective diagnostic tool so far developed for the detection of breast cancer at an early stage before it spreads to regional lymph nodes. This early detection increases the probability of cure. Mammography at appropriate intervals in asymptomatic women over age 35 years promises to reduce significantly the number of deaths from breast cancer.

Since there is now no definitive scientific evidence with regard to (1) optimal age for the initial mammogram, (2) frequency of examination, or (3) data on possible long-term radiation risk, this statement is being issued, as a summary of current informed opinion.

Care of Women With Symptoms

In women who have symptoms or physical findings suggestive of possible breast cancer, medical decisions must be individualized to fit the patient's needs. Under these circumstances, mammography is an integral part of the evaluation of the patient.

Screening of Asymptomatic Women

Recognizing that definitive data are not yet available that allow the establishment of firm criteria that define a protocol for the screening for breast cancer in asymptomatic women, the American College of Radiology (ACR) recommends the following:

1. All women should have annual physical examination of the breasts and be taught breast self-examination.

2. For asymptomatic women the first, or baseline, mammographic examination should be performed between the ages of 35 and 40 years.

3. Subsequent mammographic examinations should be performed at one- to three-year intervals unless more frequent examination is medically warranted.

4. After age 50 years, annual or other regular interval examinations, including mammography, should be performed.

5. Although the carcinogenic effects of radiation at current levels of exposure are probably immeasurably small, continuing attempts to reduce exposure should be made. However, image quality must be preserved for accurate diagnosis to insure the best risk/benefit (cure) ratio.

6. Each radiologist should assure the periodic monitoring of his equipment and procedures to determine that the patient's exposure is being maintained at the lowest feasible level.

Research Programs

The protocol currently being followed by the National Cancer Institute/American Cancer Society sponsored "Breast Cancer Detection Demonstration Projects" should be pursued so that the data are as complete and accurate as possible in order that meaningful conclusions can be drawn. Follow-up of the patients must be carried out for a number of years to insure collection and evaluation of the data. Theoretical concerns of possible radiation-induced breast cancer do not warrant change in the current protocol of the "Breast Cancer Detection Demonstration Projects." Estimates of risk that include a radiation carcinogenic effect are of dubious validity because of the lack of objective scientific evidence.

Research must be continued and encouraged to (1) improve methods for measurement of low level radiation, (2) further reduce the radiation dose in mammography consistent with good image quality, (3) determine the most appropriate age at which to begin screening for different risk groups, (4) define women of high risk, (5) define those mammographic findings that dictate re-examination at a shorter interval, (6) establish the appropriate intervals for reexamination, and (7) collect evidence of the benefits and risks of mammography.

For Further Information

If a physician wishes to talk to a diagnostic radiologist about this position paper, please call or write: Gerald D. Dodd, M.D., M.D. Anderson Hospital, 6723 Bertner Drive, Houston, Texas 77025, Phone (713) 792-2700; or Richard G. Lester, M.D., Herman Hospital, University of Texas Medical School, Department of Radiology, Houston, Texas 77025, Phone (713) 797-3664.

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Medical Board Emphasizes Policy On Temporary Medical Certificates

The State Medical Board wishes to again emphasize that temporary certificates issued under the provisions of Section 4731.291, Revised Code, are issued for educational experience within the confines of the hospital or medical school for which the certificates are issued and are not for the practice of medicine outside those institutions.

Section 4731.291, Revised Code, provides that the State Medical Board may, register, without examination, persons holding either the degree of doctor of medicine or the degree of doctor of osteopathic medicine and surgery who wish to pursue internship, residency, or fellowship programs in this State. Conditions are that:

- (1) He is at least twenty-one years of age and is of good moral character.
- (2) He has been accepted or appointed for internship, residency, or fellowship in an accredited program approved by the state medical board in a hospital or medical school situated in this State. The applicant shall indicate the beginning and ending dates of the period for which he has been accepted or appointed.
- (3) He is a graduate of a medical or osteopathic school or college which, in the judgment of the board, is reputable and in good standing.
- (4) He will limit his practice and training within the physical confines of the hospital, hospitals, or facilities for which the temporary certificate to practice is sought.
- (5) He will practice only under the supervision of the attending medical staff of such hospital or facility for which the temporary certificate to practice is granted.

The certificate shall be valid only for the period of one year, but may in the discretion of the Board and upon application duly made be renewed annually for a maximum of five years.

Ambulatory Health Care Council Begins Accreditation Program

The Accreditation Council for Ambulatory Health Care (AC/AHC), under the direction of the Joint Commission on the Accreditation of Hospitals, has begun operation of its new accreditation program. Having established standards for optimal achievable quality in ambulatory health care programs, the Council will conduct on-site surveys to measure compliance with the standards by groups applying for the accreditation process. For information, write AC/AHC, 875 N. Michigan Avenue, Chicago, Illinois 60611. Both member and nonmember groups of the American Group Practice Association may apply.

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Co-sponsored by
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Merrick Hall, Womans General Hospital

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Location: Park Plaza Hotel.

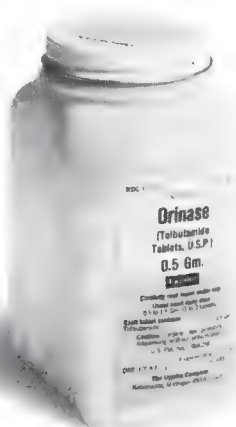
Registration Fee (includes lunch): Attending Physician \$30, House Staff Officers and Fellows \$15, Medical Students \$7, Non-Physicians \$30.

Topics include: "Current Concepts in Alcoholism"—Maxwell N. Weisman, M.D.; "Analgesics and Psychoactive Drugs in the Care of Medical Patients"—Douglas McDonald, M.D.; "The Role of the Physician in Treating the Alcoholic"—Gregory B. Collins, M.D.; "The Disabled Physician"—LeClaire Bissel, M.D.; and "The Woman Alcoholic"—Robert Bowman, M.D.

For further information contact: Academy of Medicine of Cleveland, 10525 Carnegie Ave., Cleveland, Ohio 44106, Telephone: 216/231-3500.

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Medical Hotline

House of Delegates Approves Malpractice Insurance Company

On August 1, 1976, the OSMA House of Delegates approved the recommendation of the Council that an insurance company be formed to be owned by OSMA and the physicians of Ohio and to sell medical professional liability insurance. This approval came in a 135 to 10 vote at a special session of the House of Delegates, the first time in OSMA history that such a meeting was called.

The first Board of Directors of the company, known as the Physicians Insurance Company of Ohio, will be appointed by OSMA through the Council. The members of the Board are to be George N. Bates, M.D., Toledo, Chairman; William M. Wells, M.D., Newark, Vice-Chairman; Maurice F. Lieber, M.D., Canton; Robert G. Thomas, M.D., Elyria; Stewart B. Dunsker, M.D., Cincinnati; John J. Gaughan, M.D., Cleveland; James L. Henry, M.D., Grove City; A. Burton Payne, M.D., Ironton; Hart F. Page, OSMA Executive Director; James E. Pohlman, Esq., OSMA Legal Counsel; and the president of the company, who has yet to be selected.

The original incorporators of the company, who are the physician members of the proposed Board, will be offering stock through a prospectus beginning in September 1976. Every OSMA member is encouraged to purchase shares of stock in order to assure the fiscal viability of this insurance venture.

William M. Wells, M.D., President-Elect of the OSMA, presented the report of the Council on the proposed insurance company. The report read as follows:

Mr. President and Members of the House of Delegates, the OSMA Council, as Dr. Bates has indicated, has, with the Task Force, been working diligently on researching the feasibility of forming a physician-owned professional liability insurance company. This research has proved two things which need to be clear to the members of this House.

First, the Council feels the OSMA must take some action to provide adequate malpractice insurance at a fair cost to qualified OSMA members needing this protection. The commercial insurance carriers are leaving the State of Ohio, not as quickly now, perhaps, as last year, but still leaving. The only other source of insurance for our members is the JUA, which is operated by and for State government. That means that unless we take action now, many OSMA members will have no choice but to purchase insurance through the government.

Secondly, the Council feels that the climate for malpractice is changing in our favor. Public opinion seems to be changing in Ohio away from the eagerness to sue physicians. Court reforms are slowly but surely starting to take effect. Countersuit activity by physicians wrongly sued may result in only meritorious claims being filed and taken to the courts. For these, and other reasons, then, it appears that now is a propitious time to start an insurance company, owned by the OSMA with the full and active participation of OSMA members.

The Council has also researched, in depth, the structure such a proposed company should take. The *Delegates' Handbook* reviewed the three ways such a company could be formed: (1)

Reciprocal, (2) Mutual, and (3) Stock. Of these three, the stock company appears clearly to offer the best mechanism to assure a successful venture. Reciprocal was ruled out because of the uncertainty of assessment should the project fail. Mutuals, while more advantageous than reciprocals, were also rejected because of the remoteness of the possibility of any participant ever getting back any funds given for capitalization. The stock vehicle allows the physician policyholder to purchase shares of stock instead of simply making a donation to achieve capitalization. This stock, which could be part of the physician's regular investment portfolio, maybe even part of his Keogh Plan, could eventually return the investment if the company is successful.

The Council, therefore, recommends to this House *that an insurance company be formed to be owned by OSMA and the physicians of Ohio to sell medical professional liability insurance; that the original Board of Directors be Drs. Bates, Chairman of the Board, Wells, Vice-Chairman, Lieber, Thomas, Dunsker, Gaughan, Henry, and Payne, together with the OSMA Executive Director, the OSMA legal counsel and the president of the company; that this Board be empowered to form the company immediately and that it appoint a well-qualified chief executive officer; that the company be a stock company; and finally, that the company be called the Physicians Insurance Company of Ohio; and, Mr. President, I move the approval of these Council recommendations.*

The motion was approved.

OSMA President George N. Bates, M.D., outlined the steps to be taken in the insurance company's formation in his opening remarks. The following are highlights of his address concerning formation of the company:

First, it is recommended that a stock company be formed as quickly as possible.

Stockholders and policyholders will be limited to members of the Ohio State Medical Association.

Although Ohio law requires an insurance company to be capitalized at \$2½ million, it is our intention to set a goal of \$12 million to capitalize the company. This will assure us of actuarial and fiscal soundness.

Subject to prior approval of the offering circular by the Ohio Department of Insurance, we will immediately offer shares to all members of OSMA.

It is our hope to be able to begin stock sales by September 1, 1976. This means that on or before that date, we would mail an offering circular to the membership.

It is our hope that we would achieve the capitalization quickly enough to enable us to receive a certificate of authority to begin offering professional liability policies by November 1, 1976.

The stock and the policies will be offered by direct mail. There will be no agents and, therefore, no commissions to be paid. We estimate a 15 percent savings.

There will be two classes of stock sold. Common stock will be sold to the OSMA, which will then have control of the company. Preferred stock will be sold to OSMA members. Each policyholder will be required to be a stockholder.

Only OSMA members will be eligible to apply for professional liability insurance.

The company will offer basic coverages of 100/300 with possible expansion of limits in the future.

It is our goal to have 3000 policyholders within 60 days after receiving the certificate of authority from the Department of Insurance.

(Continued on Page 472-B)

House Approves Insurance Co. (Continued)

We recommend that excess coverage be purchased by the members from the Ohio Joint Underwriting Authority or the private market until such time as our company can sell such policies.

We recommend the American Medical Assurance Company . . . organized by the AMA . . . for reinsurance.

OSMA, through the Council, will appoint the Board of Directors of the company on an annual basis. This is necessary to assure the membership that it originates as and continues as a physician-directed corporation.

Upon approval of our recommendations by this House of Delegates, the Task Force on Professional Liability will immediately begin a search to engage an expert insurance staff to administer the affairs of the company.

If the House of Delegates adopts and approves the action of the Council regarding the formation of the insurance company, it must be recognized that many decisions have yet to be made; for example, rate structures, specialty classifications, management, investment counsel, accountants, actuaries, etc. The Council believes that, while these matters are important to all members of the Association and certainly to potential policyholders of the company, they are of such a serious nature and can consume so much time in the decision-making process that these matters should be the ultimate responsibility of the Board of Directors of the new company. Any suggestions regarding such matters from any Delegate are invited to be submitted to the Council or the Board of Directors.

Countersuit Issue Also Considered by Special Session

The Special Session of the House of Delegates also undertook the question of countersuits. Many OSMA members have shown great interest in the concept of physicians who are wrongly sued having an opportunity to countersue plaintiffs and plaintiffs' attorneys who have filed the original suit. Burton Payne, M.D., member of the Task Force on Professional Liability and Chairman of Reference Committee No. One at the 1976 OSMA Annual Meeting, made the following report to the House concerning the countersuit situation:

Mr. President and Members of the House of Delegates, according to the research done to date by the Task Force, countersuit activities in Ohio have recently increased but no definitive action has yet happened. Ohio law and court rules require that a court case be finalized by withdrawal of the suit or dismissal before any countersuit may be initiated. These laws and rules are now being researched by OSMA legal counsel but the findings of that research will not be available for a few weeks yet.

The Task Force hopes that, as a result of this research, legislation may be drawn up to allow a physician wrongly sued to initiate a countersuit at some earlier point in the litigation process.

Early data from Illinois shows a drastic decrease in the number of suits filed where a physician was successful in suing a plaintiff and counsel for not doing adequate investigation and research before filing a malpractice case. This data, while not conclusive by any means, supports the theory that the Task Force should continue its work in this area.

One of the ways the OSMA might help physicians decide whether some form of countersuit would be of benefit would be to provide review by OSMA legal counsel of specific cases submitted by members. This concept was approved by the House of Delegates last May when it passed Substitute Resolution 45-76 which calls for the OSMA to "establish a mechanism to advise, assist, and support Ohio physicians regarding countersuits against such party or parties who, in the opinion of OSMA

Legal Counsel, have initiated baseless and frivolous professional liability proceedings." This review is available to any OSMA member and, like the research project, is being funded by the voluntary solicitation Dr. Bates spoke of earlier.

Mr. President, since the research project is now underway and the review mechanism is in place and available to OSMA members, it appears that this House of Delegates should reaffirm its resolve to investigate countersuits as called for by Resolutions 6-76 and 45-76 and that this House request a report at its next meeting, and, Mr. President, I move the reaffirmation of Resolutions 6-76 and 45-76.

The House approved the motion.

Federal Appointment to Robert N. Smith, M.D., Toledo

Robert N. Smith, M.D., Toledo, has been nominated by President Gerald Ford to be Assistant Secretary for Health Affairs in the Department of Defense. Dr. Smith, a graduate of the U.S. Military Academy at West Point, who resigned his commission to attend the University of Nebraska Medical School, is a past-president of OSMA.

Dr. Smith will appear before the Senate Armed Services Committee for a hearing as Senate confirmation is required for his appointment.

OMI and Medical Mutual Commence Negotiations on Consolidation

George N. Bates, M.D., President of the Ohio State Medical Association, and Edward C. Lechner, President of Medical Mutual of Cleveland, Inc., have announced the signing of a Letter of Intent to commence negotiations with the goal of consolidating the operations of the two Blue Shield Plans in Ohio through the acquisition by Medical Mutual of Ohio Medical Indemnity, Inc., a wholly owned subsidiary of the Ohio State Medical Association.

Dr. Bates and Mr. Lechner expressed the belief that such a consolidation should lead to more efficient operations and better service for the people of Ohio.

Ohio Liability Legislation For Flu Program Planned

The OSMA has been informed that Sen. Oliver Ocasek and Rep. Dennis Eckart are planning to introduce legislation at the beginning of the September session of the Ohio Legislature which will provide protection from professional liability for the professionals who participate in the impending A/New Jersey Influenza Immunization Program. It is undisputed that such protection is essential if the program is to be successfully consummated.

OSMA members are urged to contact their Ohio Representative and Ohio Senator to urge speedy passage of a bill which can provide legislative relief for the providers of these services. Support of the Ohio Hospital and Nursing Assns. and Ohio insurance groups is expected.

obituaries

JOSEPH BARTOLOMEO, M.D., Richfield; University di Bologna, Bologna, Italy, 1956; age 48; died May 14; member of OSMA and AMA.

THOMAS L. BOGARDUS, M.D., Mt. Vernon; University of Cincinnati College of Medicine, 1950; age 51; died May 10; member OSMA and AMA.

JAMES H. CARSON, M.D., Martins Ferry; Ohio State University College of Medicine, 1932; age 68; died June 17; member OSMA and AMA.

CHARLES J. CENTA, M.D., Cleveland; St. Louis University School of Medicine, St. Louis, Missouri, 1943; age 58; died in June; member OSMA and AMA.

WILLIAM O. DUGGAR, M.D., Detroit, Michigan; Ohio State University College of Medicine, 1946; age 61; died June 1.

ALBERT E. FLAGGE, M.D., Cincinnati; University of Cincinnati College of Medicine, 1932; age 70; died February 11; member OSMA and AMA.

WALTER A. KEITZER, M.D., Akron; University of Michigan Medical School, 1932; age 69; died May 6; member OSMA and AMA.

WALTER H. MALONEY, M.D., Cleveland; Temple University School of Medicine, Philadelphia, Pennsylvania, 1943; age 56; died May 18; member OSMA and AMA.

ARCHIE J. MARTIN, M.D., Adena; Ohio State University College of Medicine, 1935; age 67; died May 19; member OSMA and AMA.

RALPH W. PAGE, M.D., Cincinnati; University of Cincinnati College of Medicine, 1937; age 65; died May 18; member OSMA and AMA.

EUGENE H. PATRICK, M.D., Cleveland; Dow Medical College, Pakistan, 1957; age 47; died May 13; member OSMA and AMA.

HARRY M. SAGE, SR., M.D., Columbus; University of Michigan Homeopathic Medical School, 1913; age 87; died June 3; member OSMA and AMA.

LORNA M. SPENZER, M.D., Cleveland; University of Michigan Medical School, 1923; age 79; died February 5; member OSMA and AMA.

JOHN L. WEBB, M.D., Nelsonville; Hahnemann Medical College and Hospital, Chicago, Illinois, 1917; age 81; died May 19; member OSMA and AMA.

VINCENT WROBEL, M.D., Canfield; Ohio State University College of Medicine, 1951; age 57; died June 16; member OSMA and AMA.

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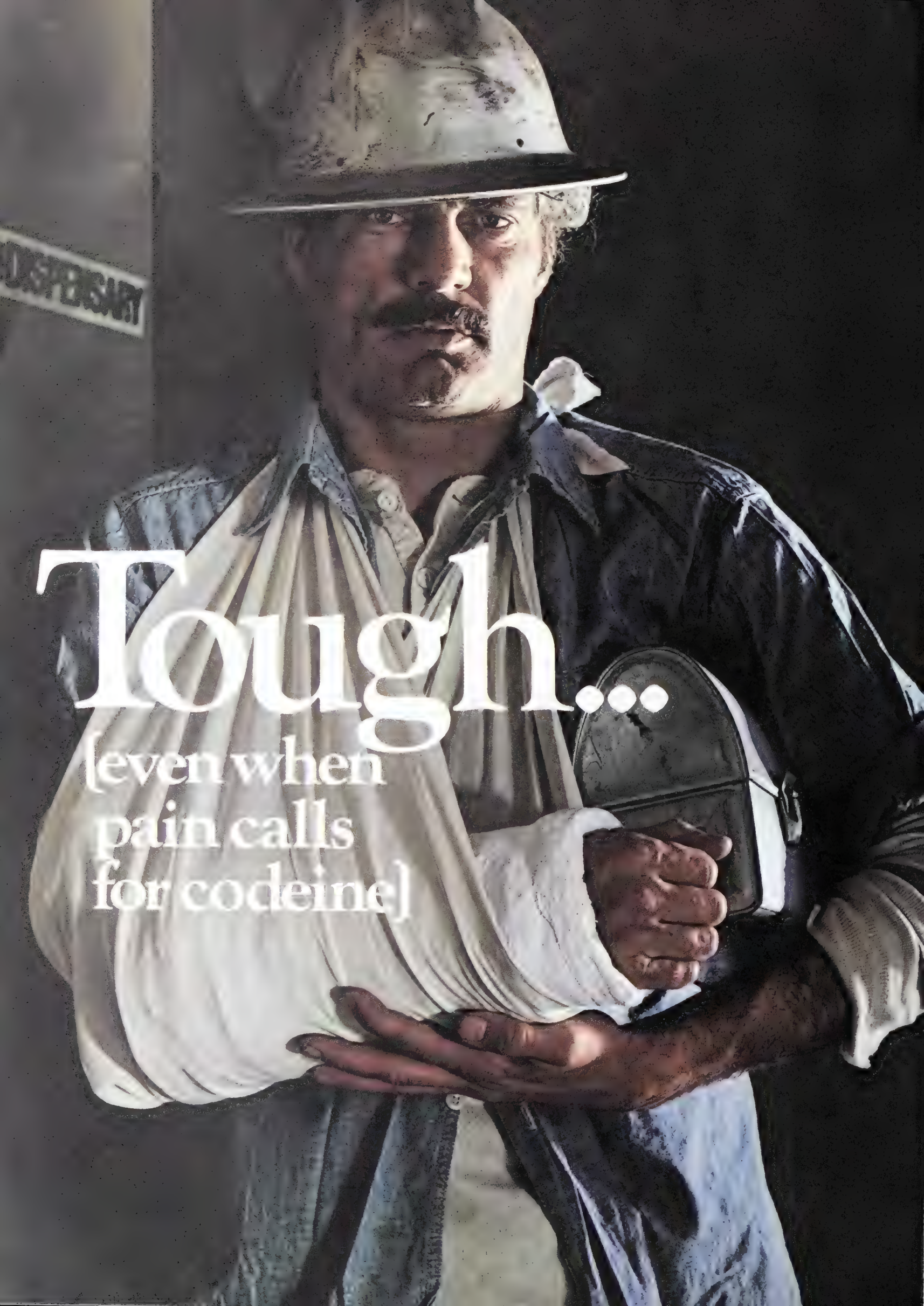
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Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

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*Mielke, C.H., et al.: JAMA
235:613 (Feb. 9) 1976

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A/New Jersey Flu Immunization Program

During the past few months, the Ohio Department of Health has been preparing for a statewide immunization program against the A/New Jersey—'76 influenza virus. There has been much confusion and controversy regarding this immunization program which is being activated by Ohio as part of the nationwide campaign. In order to clarify some points, *The Journal* presents this two-part article.

The first portion of the article is the OSMA Policy on A/New Jersey Mass Immunization. The second section deals with the program in Ohio as being directed by the Ohio Department of Health. Thomas Halpin, M.D., of the Department, is the administrator of the Ohio program.

OSMA Policy

As is widely known, the President of the United States has announced a nationwide program of immunization against the A/New Jersey strain of influenza virus.

The Ohio State Medical Association encourages physicians to involve themselves in local planning for this program — and in implementation of the program if it is initiated.

According to the present state of our knowledge and information, it is believed that the Ohio Department of Health Influenza Surveillance System, to begin on August 1, 1976, will provide the most effective technique of identification of influenza infection which may exist in Ohio — specifically including the A/New Jersey strain. The ODH System has been strengthened with the addition of viral surveillance of pediatric patients in Cleveland, Columbus and Cincinnati. The Ohio State Medical Association considers this program to be of major significance in medicine's efforts to protect the public. In order to facilitate Ohio physicians' use of this program, specific details of sample collections and handling will be published in the *Ohio State Medical Journal*.

During the first phase of the mass immunization program, physicians are expected to limit inoculations with bivalent vaccine (A/New Jersey and A/Victoria) to individuals 65 years of age and older, and to those people with chronic respiratory or cardiac conditions, or to other individuals who are deemed by their physicians to require such protection because of the status of their health.

Healthy individuals of age 24 and older should be inoculated during the second phase of the program with monovalent vaccine (A/New Jersey). HEW has not announced its program for individuals under age 24. Vaccine for both phases of the program will be made available only from the designated health agency in each county. Since dates for release of the vaccine have yet to be announced by HEW and the Ohio Department of Health, it is not possible at this time to set dates for either phase of the program.

Member physicians are encouraged to serve on countywide advisory committees organized to administer

the program — and to take an active role in implementing countywide programs.

OSMA does have the following concerns regarding the nationwide immunization program:

(1) Physicians volunteering their services in mass immunization projects should be aware that special immunity or indemnification from professional liability attendant to these projects is currently unavailable. To this end, OSMA and the American Medical Association have initiated thorough investigations of all possible avenues for relief from potential liability. So far, these efforts have proven fruitless.

Federal legislation to provide indemnity has been introduced in Congress (H.R. 14569). OSMA has asked Ohio Congressmen and U.S. Senators to support that legislation. So far, however, Congress has declined to expedite the bill.

AMA and OSMA conclude, therefore, that there is little prospect of special immunity for physicians who participate in public immunization programs. However, OSMA plans to continue efforts in this direction.

(2) OSMA is concerned that the use of available antiviral preparations (ie, amantadine hydrochloride) for prophylaxis and therapy of the A/New Jersey strain virus infection has been ignored publicly by HEW and the Food and Drug Administration, although its use in individuals who cannot receive vaccine for one or more reasons has potential benefits. (See *Journal of the American Medical Association*, Volume 235, No. 25, June 21, 1976, Pages 2739-2742, "Prevention and Control of Influenza by Chemoprophylaxis and Chemotherapy," by George Gee Jackson, M.D., Edith D. Stanley, M.D.)

(3) OSMA is also concerned with record-keeping. Physician members are cautioned that records of informed consent should be maintained by each physician in addition to those required for government use. This will assist in prompt retrieval of the consent form should the need arise.

Ohio Department of Health Program

According to Thomas Halpin, M.D., the Ohio Department of Health is currently gearing itself to the mass A/New Jersey—'76 influenza immunization program. The Department anticipates the bivalent vaccine (Victoria/New Jersey) for inoculation of high risk persons will be available shortly. It is thought that there are approximately 1.8 million such persons in Ohio. A priority list is being developed by the Department with the help of the Statewide Influenza Advisory Committee so that if bivalent vaccine is left after the high risk group is reached, certain special groups may be immunized with bivalent vaccine (ie, hospital and medical personnel and safety forces).

Monovalent (New Jersey) vaccine will be available for the bulk of the Ohio population in the early fall.

It has been determined in dosage and reaction

studies that people 24 years of age and older respond well to the vaccine. Dosage for children is questionable. Further information will be forthcoming, probably by late August.

In order to facilitate immunization, counties have been assigned "gun dates," during which times the counties will receive a specified number of injection guns to be used in mass immunization clinics. The Department emphasizes that counties will receive vaccine prior to the gun dates for use in private physician offices and certain public health clinics. A county, therefore, does not have to plan all inoculations during the gun date period.

The Department of Health will print and distribute informed consent forms for use with the vaccine. These forms will be two different colors: one for bivalent vaccine and the other for the monovalent. It is projected that the completed forms will be retained by the institution providing the immunizations (ie, schools, industry, or private medical offices) except in the case of mass clinics. The forms completed by persons participating in mass clinic inoculation will most likely be kept at the local health jurisdiction.

Records indicating such pertinent information as vaccine manufacturer, lot number, date of vaccination, age of patient, and the like will be kept in conjunction with the informed consent form.

Vaccine, needles, syringes, and injection guns will be stored in Columbus. It is anticipated that transportation for these materials to Ohio's 88 counties will be provided by contracting with private carriers and the Ohio National Guard, if necessary. Each county will have a local agency responsible for distribution of supplies within the county.

The Department plans a two-phase surveillance pro-

gram during the immunization period. The first phase will involve Akron, Cincinnati, Cleveland, Columbus, Dayton, and Toledo. In these areas, the Department will keep watch of school absenteeism, emergency room visits, and selected industrial absenteeism. Infection control personnel in the cities will be asked to be on the lookout for groups of influenza cases.

The second phase of the surveillance program involves strictly watching for the A/New Jersey—'76 strain. This phase will be carried on at one pediatric center in Cleveland, Columbus, and Cincinnati. Cultures will be done on groups of 20 children with respiratory infections seen as outpatients in each center. The viral cultures will be done in the central state laboratory with results being available inside of a week from culture date. This type of ongoing surveillance is recommended by the Communicable Disease Center in Atlanta, where it was successfully tried at Grady Memorial Hospital, picking up early influenza isolates.

The Department asks physicians who see influenza outbreaks in their practices to contact the Ohio Department of Health. For this purpose, the Department has both its main number (614/466-4643) and a "hotline" number (1/800/282-0546). The Department stresses that physicians not send cultures to the state laboratory without first contacting the Department. In this manner, the Department can coordinate laboratory activities.

The two-phase surveillance system will begin August 1, 1976, with the single exception of school surveillance which will commence with fall opening.

For further information concerning the A/New Jersey—'76 influenza immunization program, contact Thomas Halpin, M.D., the Ohio Department of Health, telephone: 614/466-4643.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** Robert * B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Vitamin B-12	1.5 mcg

Methionine	12 mg
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Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

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ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.

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Preferred Placement:

A Solution to the Physician Shortage Crisis

(**Editor's Note:** Many Ohio communities are currently facing a health care crisis in that they lack physicians. *The Journal* ran the first in a series of articles about the Ohio physician shortage problem in Volume 72, Number 2, February 1976. The following article is the second in the series and highlights an increasingly successful program, Preferred Placement, that matches physicians and locations in need of their services.)



Douglas Freeman & Michael Kirwin

Baltic, Ohio, is easy to find. It is just north of Pearl, Ohio, east of New Bedford, and a stone's throw from Rogersville. But as easy as it is to find, Baltic has not had a practicing physician since a tragic auto accident stole the life of the town doctor in 1968. As in many small communities, the residents of Baltic have made every effort to attract another physician. (See "Ohio Towns Face M.D. Shortage," *The Journal*, Volume 72, Number 2.) But Baltic, like other towns, has been unsuccessful in its search.

Today, however, thanks to a recruiting idea promoted by the OSMA combined with the dedication of Baltic's community leaders, the town of 500 people and its surrounding farming population of a few thousand have a physician who will begin his practice in a couple of years.

Baltic's future doctor is a third-year student at the Guadalajara Medical School in Mexico, Michael Kirwin. Mr. Kirwin and Baltic came together through a recruitment program that is a hybrid form of the familiar agreement under which a medical student accepts financial aid from a community in return for a commitment to practice (for a specified time) in the town at a later date.

This program is known locally as Preferred Placement. It originated at Toledo's Medical College of Ohio in order to place students from the school in areas of northwest Ohio with physician shortages. The OSMA saw a potential for the program on a statewide basis; and as a result, an increasing number of requests have been submitted for financial aid by students of other medical schools.

Preferred Placement differs from other reciprocal agreements in that it is more than a business transaction—being based on the mutual preference for one another of a medical student and a community, in hopes of the

future doctor remaining permanently. Mike Kirwin, having contacted OSMA about finding a community, was shown several towns throughout Ohio, each needing a physician. From those, Baltic was chosen as a preferred location. At the same time, various community leaders in Baltic, after talking with Mr. Kirwin at length, decided that he would fit in well with the community lifestyle. These leaders then proceeded to investigate methods of raising the necessary funds.

OSMA staff member Douglas J. Freeman commented on some of the problems associated with Preferred Placement: "One of the most difficult tasks is going to a community and convincing them that the program is one of the few viable methods of providing physicians for small communities. Many towns have been trying to get doctors for years but still are hesitant to become involved in a program that will not pay off until the student completes training and returns, usually three to five years down the road. I think, however, that with the success the Medical College of Ohio is having along with the recent Baltic placement, small towns will become increasingly interested in raising monies to aid medical students."

According to Mr. Freeman, some communities feel that they could not raise enough money to have a successful program. In answer, Freeman replied: "Baltic is a town of 500 people with maybe an area drawing-population of 6,000 or 8,000. Yet they are planning to make enough money available to Mike Kirwin to fully finance the remainder of his education and to prepare an office for his practice. Talking dollars, this means an interest-free loan of up to \$60,000."

In working further on the implementation of the program, OSMA plans to contact county medical societies in looking for potential placement sites.

Mr. Freeman concluded his thoughts about Preferred Placement by stating: "Hopefully, community leaders will decide that any inconveniences associated with raising necessary funds are outweighed by the knowledge that a physician is on the way."



Michael and Carol Kirwin



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Mailgram 2

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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COLLEAGUES IN THE NEWS . . .

ROBERT E. BARKETT, M.D., Mansfield, is the winner of the 1976 Ohio State Medical Golfer's Association Championship. Dr. Barkett, who plays to a four handicap, fired a 75 at Mansfield's Westbrook Country Club.

RUSSELL P. RIZZO, M.D., Lakewood, won low net honors among the 104 golfing physicians by posting a 79-12-67 for the 18-hole event.

Low gross and low net winners in the age flights are as follows:

Age 70 and older: **STANLEY N. P. DEVILLE, M.D.**, Lakewood, low gross; and **W. B. LIGHT**, Lima, low net.

Age 60 to 69: OSMA President-Elect **WILLIAM M. WELLS, M.D.**, Newark, low gross; and **WILLIAM A. WHITE, JR., M.D.**, Canton, and **DELBERT A. RUSSELL, M.D.**, Elyria, low net.

Age 50 to 59: **CHESTER C. KASMERKY, M.D.**, Columbus, low gross; and **JAMES L. SECREST, M.D.**, and Medical Golfers' President **C. J. SHAMESS, M.D.**, both of Mansfield, tie for low net.

Age 40 to 49: **DAVID M. BELL, M.D.**, Lakewood, low gross; and **WILLIAM IOETTMAN, M.D.**, Springfield, **THOMAS E. NETHERTON, M.D.**, Lakewood, and **ROBERT E. SOOY, M.D.**, Kettering, tie for low net.

Age 39 and under: **RICHARD R. BALLENGER, M.D.**, Columbus, low gross; and **EARL D. DEWITT, M.D.**, Columbus Grove, low net.

JOHN B. BERTE, M.D., has been named director of the Division of Pulmonary Diseases and Respiratory Therapy at Huron Road Hospital, Cleveland. Dr. Berte is a trustee of the National Board of Respiratory Therapy and a Fellow of the American College of Chest Physicians. A former member of the Participating Faculty for Inhalation and Respiratory Therapy at Tufts University School of Medicine in Boston, Dr. Berte was also director of the Department of Pulmonary Diseases at St. Raphael Hospital, New Haven, Connecticut, and Clinical Assistant Professor of Medicine at Yale University.

MILLARD C. BEYER, M.D., Akron, received a distinguished service award from the City of Akron and special service award from the Summit County Chapter of the American National Red Cross. Dr. Beyer was honored for his many community contributions including establishing health and safety programs in the area schools, launching the Learn to Swim Program—which has just completed its 29th year—, designing a swim program for the handicapped, and campaigning for a Red Cross total needs blood program. In addition, Dr. Beyer has been

active in the Summit County Medical Society, the Board of Health, Civil Defense, The Emergency Medical Service Council, and the Ambulance Service.

ELIZABETH CANNON, M.D., **LAWRENCE T. HADBAVNY, M.D.**, **JACK I. JAFFA, M.D.**, and **HAROLD R. SWAN, M.D.**, are members of Huron Road Hospital's Heart Talk team. This group was formed by the East Cleveland hospital to help those who are facing open heart surgery. A former heart patient suggested the program; and in addition to the physicians, team members include former open heart patients.

Heart Talk volunteers speak with patients before and after surgery, as well as talk with members of the patient's family. Their goal is to offer understanding, compassion, support, and encouragement for both the patient and his family.

DAN W. ELLIOTT, M.D., formerly of the University of Pittsburgh, has been appointed Professor and Chairman of the Department of Surgery at the Wright State University School of Medicine. Dr. Elliott began his teaching career at The Ohio State University where he rose from Assistant Professor of Surgery to Director of Surgical Research Laboratories and Professor of Surgery. He was then appointed Clinical Professor of Surgery at the University of Pittsburgh and later Professor of Surgery. He has held many hospital appointments, the most recent being Chief of Surgical Service at the Veterans Administration Hospital in Pittsburgh.

ATIS K. FREIMANIS, M.D., has been appointed Professor and Chairman of the Department of Radiology of The Ohio State University College of Medicine. A former medical faculty member of 12-years' standing, Dr. Freimanis was named Man of the Year by the College in 1967. Prior to his appointment, he had been serving as Professor and first Chairman of the Department of Radiology at the Medical College of Ohio at Toledo.

A diplomate of the American Board of Radiology in radiology and nuclear medicine, Dr. Freimanis is a member of the editorial board of the *Journal of Clinical Ultrasound* and a member of the standards committee of the American Institute of Ultrasound in Medicine.

MAX D. GRAVES, M.D., Springfield is the new President of the Ohio Psychiatric Association. A Diplomate of the American Board of Psychiatry and Neurology, Dr. Graves became a Life Fellow of the American Psychiatric Association in 1976 in recognition of 30 years of service to the organization. He has served as medical director of the Community Mental Health Program of Clark County and currently is one of the five directors and a member of the board. He has also been on the Governor's Task Force on Mental Health and Mental Retardation.

The other officers of the Ohio Psychiatric Association are **GEORGE T. HARDING IV, M.D.**, president-elect; **JACK MORGANSTERN, M.D.**, secretary; and **MANUEL GORDILLO, M.D.**, treasurer.

ARTHUR J. HORESH, M.D., F.A.A.P., Cleveland, was elected to the Board of Directors of the Asthma Care Association of America. His election took place at the annual meeting of the American College of Allergists held recently in San Francisco.

JAMES W. KELLER, M.D., has been named "Boss of the Year" by the Medical Assistants Society of Clark County. Dr. Keller maintains a general and vascular surgery practice in Springfield. He is on the staffs of both Community Hospital and Mercy Medical Center and serves as a volunteer physician with the Neighborhood Church Clinic. He holds memberships in the county, state, and national medical associations as well as the American College of Surgeons, the American College of Utilization Review Physicians, and the Western Ohio Foundation for Medical Care. Dr. Keller is a past-president of the Drug Control Council of Clark County and has served as an assistant clinical professor at the Wright State University School of Medicine.

ROSS M. KNOBLE, M.D., Sandusky, has retired as chief medical officer of the Ohio Soldiers and Sailors Home hospital after nearly 18 years at the state institution for Ohio veterans. Dr. Knoble is a past president of the Ohio Academy of General Practice and the Erie County Medical Society and a former OSMA councilor and is on the Providence Hospital staff. He also served as chief of staff at Good Samaritan Hospital, taught at the Providence School of Nursing, and was plant physician at New Departure Hyatt.

Wright State University School of Medicine faculty members **DOUGLAS LONGENECKER, M.D.**, and **JOHN C. WRIGHT, M.D.**, have been appointed to key roles in developing the Core Content Review, a self-learning, self-assessment program for family physicians offered by the Connecticut and Ohio Academies of Family Physicians.

Dr. Longenecker, Associate Professor and Chairman of the Wright State Department of Family Practice, is a member of the Executive Committee of the Review. Its primary responsibility is overseeing the quality and structure of the examination program.

Dr. Wright, Associate Professor and Vice-Chairman of the Department of Family Practice, is currently serving his second year as Educational Director of the Review. His major concern is with developing a national faculty to prepare questions for the education program.

C. WILLIAM LOUGHRY, M.D., has been appointed the full-time, hospital-based Chairman of the Department of Surgery of Akron City Hospital. He has served as chairman of the department since 1972. A Fellow of the American College of Surgeons, Dr. Loughry is also Clinical Assistant Professor of Surgery at The Ohio State University College of Medicine and a member of the Council of Chiefs in Surgery of Northeastern Ohio Universities College of Medicine.

The Ohio State Radiological Society has elected officers for the 1976-1977 calendar year. Those honored by the Society are **TEARLE L. MEYER, M.D.**, president; **N. RAYMOND BAUMGARTNER, M.D.**, president-elect; **JAMES P. FARMER, M.D.**, secretary; and **S. THEODORE PINSKY, M.D.**, treasurer.

NICHOLAS MICHAEL, M.D., Columbus, Clinical Professor Emeritus of Psychiatry at The Ohio State University, received a Certificate of Leadership from the Council of the Ohio Psychiatric Association. This certificate acknowledges Dr. Michael for 25 years of service to Ohio psychiatry. A Life Fellow of the American Psychiatric Association, Dr. Michael is also a past president of the Ohio Psychiatric Association. In 1975, he received the Alumni Achievement Award from The Ohio State University. Currently, he is on the senior attending staffs of Riverside Methodist and Grant Hospitals.

PIERCE H. MULLALLY, M.D., has been named Director of Occupational Medicine for Republic Steel Corporation. Dr. Mullally began his service with the company in 1954. He is on the staff of St. Vincent Charity Hospital, Cleveland, where he was director of the Department of Surgery for eight years. In addition, he has been associated with the Cleveland Clinic Educational Foundation.

WILLIAM J. ROSS, M.D., Orwell, was named Grand Valley Citizen-of-the-Year. Dr. Ross, a graduate of the medical school of the University of Western Ontario, has practiced surgery, obstetrics, and general medicine in Orwell since 1933.

WILLIAM A. SODEMAN, SR., M.D., received an honorary doctor of medical science degree at the June commencement of the Medical College of Ohio at Toledo. Dr. Sodeman, who resides in Toledo, is a clinical professor of medicine on the part-time faculty of the College. He is also Dean Emeritus and Professor of Medicine Emeritus of the Jefferson Medical College, Philadelphia, and is past-president of both the American College of Physicians and the American College of Cardiology.

ROBERT E. TSCHANTZ, M.D., Canton, was unanimously reelected President of the Board of Trustees of the Northeastern Ohio Universities College of Medicine. Dr. Tschantz, who is an OSMA Delegate to the AMA, will serve for the College's next fiscal year, July 1, 1976 to June 30, 1977.

SYLVAN L. WEINBERG, M.D., Dayton, is Chairman of the 1976 Scientific Program Committee of the American College of Chest Physicians. Dr. Weinberg is Clinical Professor of Medicine at Wright State University School of Medicine and is also co-editor of *Heart and Lung*, the official publication of the American Association of Critical-Care Nurses.

Report on AMA Auxiliary 1976 Convention

Joy Myers, OSMA Auxiliary President

The OSMA Auxiliary answered the roll call at the American Medical Association Auxiliary 1976 Convention with 17 delegates, two alternates, and two national board members in attendance. Those who participated were President of the Delegation Fran Krone (Mrs. Robert), Chairman of the Delegation Joy Myers (Mrs. William), and National Delegates Jane Sloan (Mrs. Malachi) and Ludel Sauvageot (Mrs. J. Paul). Ohio Delegates were Louise Bates (Mrs. George), Mary Becker (Mrs. Dwight), Jean Chrenka (Mrs. Paul), Theresa Crawford (Mrs. Henry), Olean Demmy (Mrs. Nicholas), Jo Frye (Mrs. Carl), Jane Hammon (Mrs. Jerry), Mary Anne Harshman (Mrs. Kenneth), Florence Kaplan (Mrs. Joseph), Angie LaMaida (Mrs. Vincent), Eileen Loria (Mrs. Louis), Ingrid May (Mrs. Albert), Gloria Naji (Mrs. Abdul), and Mary Smith (Mrs. David). Alternate Delegates were Jane Perchan (Mrs. Robert) and Ruth Robeck (Mrs. John).

Ohio's entry in the AMA Auxiliary seal contest was voted the winner. The design was done by Gloria Naji of Gates Mills. Another honor to Ohio was Jane Sloan's installation as National Secretary. In addition, Fran



The Ohio contingent

Krone was selected First Alternate to the National Nominating Committee.

Highlights of the convention included the listing of the Project Bank as a standing committee of the AMA Auxiliary. This Committee will be responsible for assembling information about all types of county auxiliary activities. These project ideas will then be available to other county and state auxiliaries as stimuli for future plans.

It was announced that the Woman's Auxiliary to the Student American Medical Association had been dissolved. The AMA Auxiliary made provision for spouses of medical students to join its ranks as junior members through the county auxiliaries. Ohio will make a concerted effort to encourage such affiliation.

The 1976 Leadership Confluence will be held October 10-13 in Chicago. Ohio will send ten Auxiliary members to this meeting which proved very valuable last year.

Finally, mention was made of the successful endeavors on the part of the Auxiliary for the benefit of AMA-ERF. Total contributions for 1975-1976 were \$1,434,564.08.



Left to right: Immediate Past-President Fran Krone, AMA Auxiliary Seal Designer Gloria Naji, and President Joy Myers.



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HERBERT A. SIHLER Jr.
President

OSMA Protests Political Ad

(Editor's Note: The following telegram was sent by George N. Bates, M.D., on behalf of the OSMA, to protest a political advertisement used by Howard Metzenbaum in his primary election campaign. This telegram is an example of the OSMA's diligence on behalf of its member physicians.)

Howard Metzenbaum:

Your political advertisement on television insinuating that the death of a patient would have been prevented by a federal health care program is in monumental bad taste and grossly misleading.

What were the medical circumstances of the "case" referred to by the "doctor" appearing in your commercial? Does the federal government have some secret remedy that could have saved your "patient"?

In the reality of medicine, physicians frequently must inform relatives of patients that everything possible was done in attempting to save the patient. It is a cruel and inhuman act for you to confront newly bereaved relatives with this political quackery. You have failed to consider the emotional and psychological impact on bereaved relatives who have just been confronted with the reality of death and suddenly find themselves assaulted by the unreality of your political advertisement.

The Ohio State Medical Association asks that you withdraw this political advertisement immediately.

George N. Bates, M.D., President
Ohio State Medical Association

Columbus Physician Supports OSMA Malpractice Research Fund

Throughout our experience with the malpractice crisis, we have been forced to work as blind men dependent on a few facts grudgingly supplied from vague sources. Four thousand dollars was the estimate given to me for gathering minimum data about the incidence of

local malpractice actions. Even information in public domain must be gathered and processed by someone with at least a minimum of legal training. It seemed to me too large an undertaking for the local Academy.

You have received a letter asking for a donation to support fact-searching effort by the Ohio State Medical Association. I have no detailed knowledge of the proposal but our District Councilor, J. Hutchison Williams, assures me the State Task Force is proceeding in a responsible and vigorous manner.

The State Task Force proposes to determine, at least for the major metropolitan areas, the trend of malpractice incidence, the results of recent suits and the impact of recent legislation and publicity. It hopes to gain access to some facts about the insurance industry, particularly the rate-setting mechanisms. We would be naive to expect a gigantic refund if actuarial predictions turn out to be far-fetched, or that the protection rip-off will be corrected, but even a blind man has the right to know who is picking his pocket and for how much. Send \$100.00 and find out. If you think this is a half-baked idea, send \$50.00.

Jack E. Tetirick, M.D., President
Academy of Medicine
Columbus and Franklin County

(Reprinted from the Academy of Medicine of Columbus and Franklin County *Bulletin*, Volume 42, Number 5.)

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Total Knee Arthroplasty

An Introduction to the Sheehan Prosthesis

David K. Halley, M.D.

The Sheehan total knee prosthesis consists of two main components — the femoral and the tibial. Bearing materials are chrome-cobalt alloy and high-density polyethylene. The high-density polyethylene, which forms the upper part of the tibial component, is housed in a metal container with an intramedullary stem. This is a very stable knee prosthesis which can withstand almost any type of arthritis regardless of the amount of varus or valgus deformity. It is used in those instances where a hinge-type knee arthroplasty has been used previously. However, it takes away virtually no bone, as compared to a hinge-type prosthesis and, therefore, a salvage procedure can be performed if infection should occur. The designed range of motion approximates that of a normal bone.

NOT ONLY SHOULD THE DESIGN of a total knee replacement simulate normal knee function as closely as possible, but its use should be applicable to all degrees and varieties of pathologic disorders involving this joint. No knee should be considered too damaged, too unstable, or too angulated for reconstruction. In addition, reconstruction should be an easy, safe, and reliable procedure.

If the design is based on the forces transmitted by the joint, and provided low frictional materials are used, mechanical failure should virtually be eliminated and

failures become synonymous with infections. A salvage procedure for the latter problem must be available.

The Hinge-Type Prosthesis

The current trend in prosthetic knee joint replacement is toward safety in the event failure occurs. This has led to the use of condylar replacements, but oftentimes they cannot be used because of marked instability of the joint. In soft osteoporetic bone, as frequently encountered in rheumatoid arthritis, fixation could present as a problem regarding long-term loosening. The ideal method for fixation is the use of intramedullary stems. This method has been used previously in the form of a hinge-type prosthesis; however, use of this type of prosthesis requires resection of a great deal of bone from the articular surfaces. If infection should occur, it is most difficult to achieve a salvage procedure using an arthrodesis technique and, in some instances, amputation has been necessary.

A second criticism of the hinge prosthesis is that it always allows motion to occur in the flexion-extension plane but has no capacity for rotation, a normal motion incurred in the knee. Inability of the hinge to allow rotary motion causes increased stresses on the hinge device or at the cement-bone junction. This could lead to fracture of the prosthetic implant or loosening at the cement-bone junction.

The Sheehan Prosthesis

The Sheehan prosthesis has been designed with the foregoing requirements in mind. It consists of two main

Dr. Halley, Columbus, Attending Staffs, Mount Carmel, Riverside Methodist, and St. Ann's Hospitals.
Submitted December 4, 1975.



FIG. 1. Anteroposterior view showing metal femoral component articulating with high-density polyethylene surface of tibial component. This polyethylene stud affords more stability.

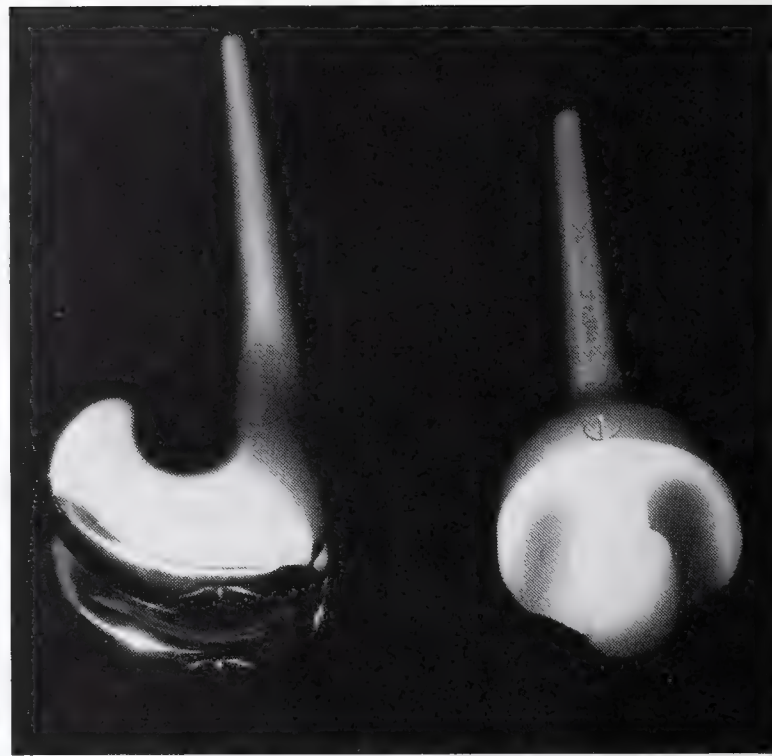


FIG. 2. Femoral (left) and tibial (right) components show intramedullary stem which enhances fixation. Femoral component has same polycentric configuration as normal knee.

components, the femoral and the tibial component. The varying materials are chrome-cobalt alloy and high-density polyethylene. This provides for low-frictional surfaces at the articular interface. The high-density polyethylene, which forms the upper part of the tibial component, is housed in the metal container with an intramedullary stem. The intramedullary stem, which achieves the ideal method for fixation and alignment, also is designed into the femoral component made of chrome-cobalt alloy (Figs. 1 and 2).

The range of motion of the prosthesis simulates normal knee movement, ie, -5° to 130° flexion. There is stability in the extended position without rotation, but rotation gradually increases to 20° when the knee is flexed to approximately 60° . As the shape of the condylar component is the same as that of a normal knee, the axis is movable, and consequently, the axis moves during flexion. No side-to-side movement is permitted, and minimal backward-and-forward movement occurs, simulating cruciate action.

These complex movements are possible because of the geometry of the high-density polyethylene tibial stud and reciprocally shaped locating tracts on the inner aspect of the femoral-bearing surfaces. Viewed from the inferior aspect, the gap between the femoral surfaces is diverged posteriorly thereby allowing increasing degrees of rotation with flexion. The outer surfaces of the femoral bearings are parallel at all times.

When a knee with an inserted rigid hinge is flexed beyond 90° , the compressive force transmitted to the stem is changed to a distraction force which might lead to

loosening of the prosthesis. To obviate distraction forces in one or another component, no firm linkage exists between either component when the knee is flexed beyond 100° . Thus, if apposition of soft tissue does occur in the posterior aspect of the knee, the tibial stud is free to sublux anteriorly from the femoral component (Fig. 3).

The insertion technique necessitates removal of the central aspect of the joint, but this allows the lateral surfaces of the joint to remain, leaving sufficient bone present for an arthrodesis if infection should occur. The prosthesis is almost totally enclosed in bone, with only the bearing surfaces exposed. The cement also is buried beneath the prosthesis, decreasing the chance of possible third-particle wear from the cement particles. Figures 4, 5, and 6 demonstrate this prosthesis in situ.

Conclusion

Personal communication with James Sheehan, the developer of this knee arthroplasty, demonstrates that



FIG. 3. Tibial stud is free to sublux anteriorly from femoral component.

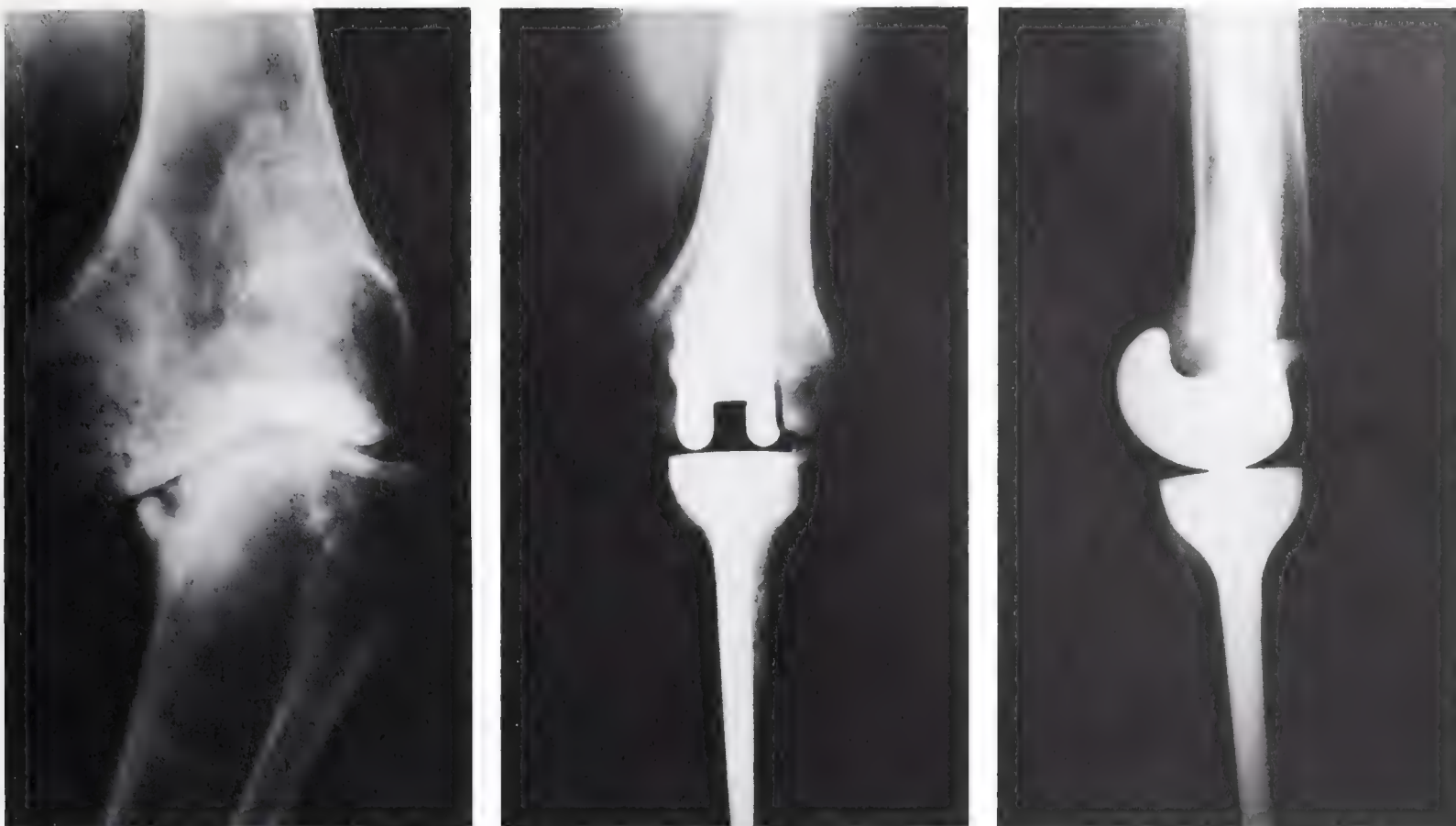


FIG. 4 (left). Anteroposterior view (preoperative) of knee severely damaged by osteoarthritis with marked varus deformity and instability. FIG. 5 (center) Anteroposterior view of Sheehan knee arthroplasty demonstrating correct alignment to knee with stability offered by prosthetic design. FIG. 6 (right). Lateral view of components in correct position with knee in full extension.

the performance of this prosthesis has been very gratifying. With the longest follow-up being only four years, it still is too early to assess the results in most patients on a long-term basis. However, a very satisfactory return of knee function can be expected in the majority of patients.

Reference

Sheehan J: "Arthroplasty of the knee," in *The knee joint: Recent advances in basic research and clinical aspects. Proceedings of the International Congress, Rotterdam, Sept 13-15, 1973*, Ingwessen, et al (eds), New York, Elsevier Publishing Co, 1974.



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Educability in Medicine: Comparative Performances of American Students Attending a Domestic and a Foreign Medical School

Harvey J. Dworken, M.D.; William A. D'Angelo, M.D.; and Marcia Z. Wile, Ph.D.

The opportunity to teach a course in gastroenterology to English-speaking students in their sixth semester of study at the Universidad Autónoma de Guadalajara (UAG), Mexico, made it possible to compare the educability of these students with that of second-year students at a United States medical school, Case Western Reserve University (CWRU). Both groups were taught similarly by members of the same faculty, from the same syllabus, and in roughly the same amount of time. Evaluation of students was through an examination of 117 objective questions, identical at both schools. Students evaluated the course by questionnaire. Results show that CWRU students scored significantly better than the UAG students ($p < 0.01$), although there was a considerable overlap in the results. Data are interpreted as showing that around 63 percent of UAG students show promise of success in Fifth Pathway Programs such as that recently commenced by CWRU in conjunction with the Northeastern Ohio Universities College of Medicine (NEOUCOM).

Editor's Note: Section 3333.16 of the Ohio Revised Code mandates the establishment of at least one Fifth Pathway Program for Ohio citizens who receive their medical education in Mexico or under circumstances similar to those at Guadalajara. One such Fifth Pathway Program has been established under the auspices of Case Western Reserve University School of Medicine and the Northeastern Ohio Universities College of Medicine.—R.L.M.

UNITED STATES CITIZENS attend the Faculty of Medicine at the Universidad Autónoma de Guadalajara (UAG) in Mexico either because they have applied unsuccessfully to medical schools in the United States or because they feel that their applications would have been rejected had they been submitted. Much has been written about the Guadalajara experience,¹⁻⁵ tending to place the school and the achievement levels of the students in a fairly poor light. However, there are no data available which measure the educability or the capability to practice medicine of U.S. students at UAG. The present study focuses on educability, by comparing the

achievement levels of a class of UAG students with a class of U.S.-based students after having been taught essentially the same course by a similar faculty.

In the spring of 1974, the opportunity was provided for a group of instructors from Case Western Reserve University (CWRU) to teach a complete course in gastroenterology to English-speaking students at UAG. The faculty* was permitted to operate as it pleased, and adequate facilities were made available for this purpose. At the conclusion of the course, the examination given at the UAG was exactly the same as that used three months earlier in the year at CWRU. Virtually all of the questions were new to students at both schools, having been set specifically with this project in mind. Students at neither school were aware that a comparison was being made. It is the purpose of this report to present the results of the teaching program and the evaluation.

Materials and Methods

Students.—The second-year class at CWRU consisted of 128 medical students and 14 students who were candidates for both MD and PhD degrees. The UAG class consisted of 296 students in their sixth semester of study. While a few of these students were not actual citizens of the United States, all were fluent in English.

Faculty.—The faculty at CWRU in 1974 consisted of 13 internists, nine surgeons, one parasitologist, one pathologist, and one radiologist, in addition to 12 laboratory preceptors in pathology. Participation by each of the faculty members in the 53 nonlaboratory hours of teaching ranged from 1 to 25 hours. A great deal of parallel teaching was done during 16 hours of discussion when the class was divided into six small groups. By contrast, the UAG faculty consisted of four internists and one surgeon, all of whom had taught at CWRU either in 1974 or as

*Faculty included Drs. Donald D. Anthony, Jerome J. DeCosse, Lansing C. Hoskins, and Reed T. Keller, in addition to Dr. Dworken. The examination was prepared largely by Drs. Kevin T. Geraci and Harold P. Roth.

recently as 1972 and, thus, were quite familiar with the program.

Curriculum.—The course, recently described in detail,⁶ consists of syllabus readings followed by illustrated lectures for the entire class and, thence, by discussion groups which feature the analysis of case problems contained in the syllabus. The CWRU syllabus⁷ was reproduced at the UAG prior to its actual publication, and each student was provided with a personal copy.

Lectures were essentially the same at each school although the smaller faculty at UAG limited the breadth and richness of the content presented. No lectures on nutrition were given at UAG; laboratories in pathology, gastric secretion, and stool examination had to be omitted because materials were lacking. The absence of pathology laboratories was compensated for by the use of color lantern slides prepared for students at CWRU and shown in whole-class exercises at UAG. These slides are available for private study at CWRU, but were not in Mexico.

Each discussion session at CWRU was planned so that one preceptor was assigned for each group of 24 registered students. This intimate ratio was not possible at UAG since no more than three faculty members were in Guadalajara at any one time. Thus, approximately 100 students were assigned to each group. At both schools, the students remained fixed and the faculty rotated from one discussion period to the next.

Facilities.—Lecture halls and class rooms were comparable at both institutions and accommodated the assigned numbers of students adequately. Both schools are housed in modern quarters; projection and amplification equipment was generally available and in good order.

Clinical Experience.—During the period of the gastrointestinal committee teaching at CWRU, students are offered an option to meet with a faculty member one afternoon weekly in groups of ten or less. At these meetings, relevant cases are discussed, patients interviewed, x-ray films and hospital charts examined, and laboratory data analyzed in an effort to enrich the subject matter being taught in the morning classes. Similar sessions were held twice weekly at the UAG, but the lack of hospitalized and out-patients often made it necessary for “imaginary” cases to be defined by the preceptor.⁸ Occasionally, a student would invite a patient seen earlier in a neighborhood clinic to attend these exercises.

Examination.—The same objective examination, consisting of 117 questions, was given to both groups of students during the final three hours of the course. The questions followed the format used in National Board examinations. CWRU students are quite familiar with this format since it is employed in almost all of their course examinations during the first and second years of school and in the comprehensive examination set at the end of the first year. Many UAG students, on the other hand, are not as familiar with this format since most of the previous examinations at that school were of the essay type.

For the statistical evaluation, 17 questions were dropped from consideration—four because of ambiguities

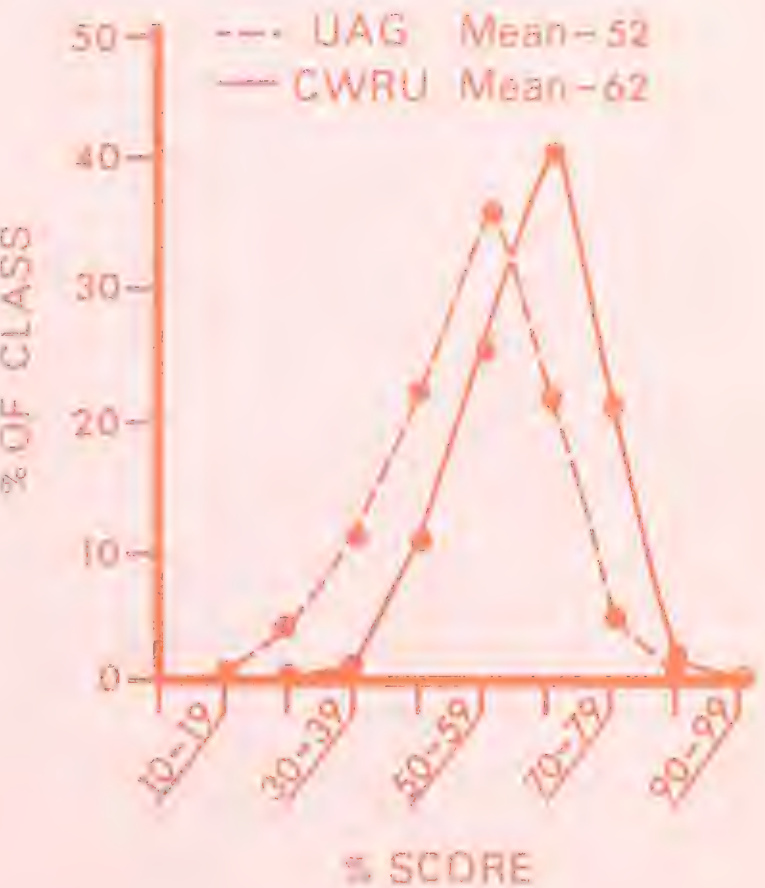
and 13 because they were on topics not amply covered in the UAG curriculum. Analyses, therefore, were made only on the remaining 100 questions.

Questionnaire.—Written comments about any aspect of the course were solicited from both groups of students after the examination. Among other features, they were asked to rate the course on a basis of one to five, with one being low, three—average, and five—high.

Results

The mean score achieved by the CWRU students was 62 percent (sd-9), while the mean score of UAG students was 52 percent (sd-11). The standard error of the difference of these means is 0.989 percent, and the value for t is 10.11. Chance probability for a t value of this magnitude is well below 1 percent. Thus, the difference is highly significant and shows that the CWRU and UAG students perform at different levels of achievement. Although 15 percent of the UAG students scored below 40 percent on the examination, the distribution of scores is not skewed (Figure).

The Table indicates considerable overlap in examination scores among the two groups of students, 62.6 percent of CWRU students and 27.1 percent of UAG



Distribution of Scores on Achievement Examination.

Results of Examination Showing Number of Students and Achievement Levels

Percent Score	CWRU		UAG	
	No. of Students	Percent of Class	No. of Students	Percent of Class
20-29	0	0	12	4.0
30-39	1	0.7	33	11.1
40-49	16	11.3	65	22.0
50-59	36	25.4	106	35.8
60-69	57	40.1	65	22.0
70-79	30	21.1	15	5.1
80-89	2	1.4	0	0
Totals	142	100.0	296	100.0

students receiving a grade of 60 percent or higher. One hundred and twenty-five (88 percent) CWRU students and 186 (62.9 percent) UAG students scored 50 percent or higher on the test and, thus, could be considered to have achieved a "passing" grade.

Results of the questionnaire at CWRU were favorable; they have been reported previously.⁶ Sixty-one percent of the students submitted a questionnaire, and they rated the course at 4.2. In Guadalajara, 250 students (84.5 percent of the class) returned the questionnaire, and the average rating of the course was 4.5. Many students in both groups were highly critical of the examination, feeling that the questions were too hard, that overly much attention was paid to details, and that the time was too short. However, a number of students at both schools felt that the examination, though rigorous, was a proper test of their ability to analyze clinical problems.

Discussion

The data indicate that the second-year students at CWRU represent a population clearly different from the population of sixth-semester students at the UAG. The reasons for this difference are not evident from the results as presented, but a number of possible explanations come readily to mind. First, and perhaps foremost, is the fact that the student bodies at the two schools are drawn from different levels of the total applicant pool. CWRU students are primarily those with highly successful academic records in undergraduate colleges, while UAG students usually have performed less well in the past. Furthermore, many of the UAG students are older than the usual student at medical schools in the United States, having settled upon medicine as a second career following years spent in related and nonrelated fields. Basically, the UAG students are ambitious people who, for one reason or another, have been refused admission to a school in the United States, or have never applied. But recognition of this fact does not answer the perplexing question of whether or not UAG students are educable in their chosen career of medicine and, hence, are suitable for practice in their homeland.

The data available up to now show that U.S. students at the UAG have not performed well on such summative tests as Part I of the National Board,¹ or on the Educa-

tional Council of Foreign Medical Graduates (ECFMG) examinations. In 1974, only 86 of 302 UAG candidates (28.2 percent) passed the latter exercise.⁹ But these examinations test *achievement* rather than *educability*; they are not proper vehicles for comparing groups of students or for contrasting the quality of one school with another. In addition to differences in faculty, curricula and teaching techniques vary greatly. Some schools allow long study periods before these examinations are taken, while others offer none. It is alleged also that previously used examination questions are available for review in some places. Furthermore, a number of entrepreneurial courses have been established which essay to prepare candidates for both the National Board and the ECFMG examinations. While none of these facts should be construed as criticisms of these examinations in themselves, they do indicate that these established tests cannot be used credibly in determining a student's eligibility to practice medicine unless the previous education also has been carefully analyzed. This study serves to minimize other variables in an effort to focus on educability alone.

Given the difference in the student body at the two schools, coupled with the fact that the course in gastroenterology was fairly strenuous, the faculty smaller and less than ideally constructed, and the examination style new at the UAG, it is not surprising that the CWRU students performed in a significantly superior fashion. It perhaps is more surprising that so many of the UAG students did so well in comparison with the CWRU group, particularly when the additional disadvantage of having received their basic science teaching in Spanish is also considered. Had it been possible to test both groups prior

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Reprint requests to 2065 Adelbert Road, Cleveland, Ohio 44106 (Dr. Dworken).

Submitted June 2, 1976.

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(continued on page 495)



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(continued from page 492)

to the course, the UAG group may have been shown to have acquired a greater increment of knowledge than is apparent from a review of the examination results alone.

If educability in a didactic setting indicates later success in clinical experience, it is apparent from these results that many UAG students (approximately 63 percent) are likely to become able clinical clerks in the future. On the other hand, some students at both schools (12 percent at CWRU and 37 percent at UAG) did indeed perform marginally, scoring less than 50 percent on the examination. If this performance is representative of achievement in other subject areas, these students may require tutoring or perhaps may need to be counseled against taking further professional training.

Presently, a score or more states and jurisdictions in the Union, including Ohio, have adopted Fifth Pathway legislation which enables medical schools to offer a year of guided clinical training to U.S. citizens who have completed four years at the UAG. The program, operated jointly by CWRU and NEOUCOM, began in January 1976 with three former UAG students; eight students commenced the program in July 1976. The conclusion of this study—that at least two-thirds of U.S. students at UAG appear to be educable by stateside standards—

should be reassuring to schools either already embarked on or planning to commence Fifth Pathway programs.

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References

1. Egan RL: U.S. citizens and foreign medical schools. *JAMA* 232:1028-1030, 1975.
2. McGough WE: Fifth pathway in New Jersey. House officer preparatory course for U.S. foreign medical graduates. *JAMA* 232:1031-1033, 1975.
3. Greer JE: A view from south of the border. *JAMA* 232: 1036-1037, 1975.
4. D'Angelo WA: In reply to Dr. Derbyshire. *JAMA* 232: 1040, 1975.
5. McDonald J (ed): The muddle over medical manpower. *Prism* 3:8-63, 1975.
6. Dworken HJ: Guided self-education in the undergraduate teaching of gastroenterology. *J Med Educ* 49:681-685, 1974.
7. Dworken HJ: *The Alimentary Tract: Basic Principles and Case Problems*. Philadelphia, Saunders, 1974.
8. Moser RH: Ruminations. The Guadalajara dilemma. *JAMA* 232:1042-1043, 1975.
9. McGuinness AC: Performance of US citizen candidates on the January 1974 ECFMG examination. *JAMA* 229: 431-434, 1974.

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The Functional Aspect of the Urethral Syndrome

Jack L. Summers, M.D.

In an attempt to define functional overlay in female patients with urethral symptoms and to devise a simple, rapid-screening device, 50 female urologic patients with lower urinary tract symptoms were screened consecutively with the Cornell Depression Index-Health Questionnaire (CMI) and the Self-Rating Depression Scale (SDS), and were compared with healthy student nurses and nonurologic hospital controls. Although the results are not diagnostic, a high yield of organic pathology may be expected if results of both questionnaires are negative. If both the CMI and the SDS results are positive, a very strong functional overlay exists. This should be considered in the care of the patient. The forms are simple, self-administering, and require no physician time to administer or score. When used at random, they may afford the urologist a better insight into the emotional make-up of a patient with urethral syndrome.

IT HAS LONG BEEN the impression of the clinical urologist that functional overlay plays an important role in the development and therapy of the female patient with chronic, lower-urinary-tract symptoms. The exact form of this functional aspect of lower-urinary-tract symptomatology has not been adequately defined. This pilot study was initiated to devise a simple, economic screening device to help define and document the functional component of the urethral syndrome.

Materials and Methods

One hundred subjects were divided into three groups, as follows:

Group 1.—Twenty-five asymptomatic, female, student-nurse volunteers with no history or symptoms of urinary-tract disease. This was a control group.

Group 2.—Twenty-five female, surgical, nonurologic hospital patients admitted to the general surgery service for nonurologic disorders. This control group had neither history nor symptoms of urinary-tract disease.

Group 3.—Fifty female patients admitted consecutively to the urology service with complaints confined to the lower urinary tract.

All subjects were asked to complete the Cornell Medical Index and the Self-Rating Depression Scale.

Dr. Summers, Akron, Staff Member, Akron Children's and Akron City Hospitals, and Akron General Medical Center. Submitted January 3, 1976.

Group 1 completed the forms at random, while Groups 2 and 3 completed them as part of their routine admission evaluation before any procedures were accomplished. No attempts were made to screen patients on a basis of their history in the control groups. All the patients in Group 3 were followed until the time of their discharge from the hospital.

Cornell Medical Index-Health Questionnaire

The Cornell Medical Index-Health Questionnaire (CMI) was devised to meet the need for an instrument suitable for collecting a large body of pertinent medical and psychiatric data at a minimal expenditure of the physician's time. It has been tested vigorously, and yields data which can generally be relied on as accurate.¹⁻³

The CMI is a four-page questionnaire made up of 195 easily understood questions answered by an appropriately circled "yes" or "no" on the answer sheet. Technical terms are avoided, and a simple reading knowledge of the English language is sufficient to complete the form.

There are four types of questions related to present illness, past illness, family history, and behavior or mood. The test is divided into two forms, based on sex, it is self-administering and requires about ten minutes to complete.

The interpreters of the CMI identified 94 percent of the diagnostic categories in which disease was found on hospital investigation. No specific training is needed to interpret the form.

A medically significant emotional disturbance may be suspected when any of the following is evidenced on the CMI:

- 30 or more "yes" answers on the entire test
- 3 or more "yes" answers on Section I or Section J
- 3 or more "yes" responses on the last page of the form
- 4 or more questions not answered, or answered "yes" and "no"

Table 1 lists percentages correlated with the diagnosis for four sample groups of women who gave "yes" responses in the CMI.

Self-Rating Depression Scale

A Self-Rating Depression Scale (SDS) for the quantitative measurement of depression and other emotional disorders was first reported in 1965.^{4,5} Further studies in

TABLE 1. Percentage of "Yes" Responses on CMI Questionnaire from Four Sample Groups of Women

No. of "Yes" Responses	307 N.Y. Hospital Employees "Normal" %	328 N.Y. City Ostensibly Healthy %	3,014 N.Y. Hospital Patients %	343 N.Y. Hospital Neurotic Patients %
10 or more	43	79	84	99
20 or more	13	51	62	83
30 or more*	5	30	44	65
40 or more	2	16	30	49
50 or more*	1	9	18	34
60 or more	0	5	10	21
70 or more	0	2	5	12

*Suggested critical scoring levels

the aged and on factors influencing the scale were published in 1967.^{6,7}

Testing and scoring require less than five minutes.

The form consists of 20 simple questions answered by: "none of the time," "some of the time," "good part of the time," or "all of the time." Relative values are placed on the appropriate answers and a raw score obtained which is converted to a rating scale. Diagnosis and scoring are illustrated in Table 2.

Ratings below 40 indicate little or no depression. The SDS does not differentiate depression as an illness from depression as a symptom, but rather serves to quantitatively measure the intensity of depression, regardless of diagnosis.

Results

The study results are summarized in Table 3, and a correlation of the results of the tests in Group 3, as related to disease, is summarized in Table 4.

Discussion

Age, marital status, educational background, or ethnic origin were not significant in any of the groups. Control Group 1 showed the lowest average SDS score, with only three positives among the 25 student nurses. This correlates well with the amount of depression expected among professional students.¹⁻³

In the CMI questionnaire, only 13 students showed an entirely negative profile, but this represented one-half of the control group. Of the 12 strictly considered as suggestive of emotional disturbance by the rigid scoring of the questionnaire, nine of these were positive on the basis

of four or more positive answers on only the last page of the questionnaire. (This section deals heavily with moods, feelings, and attitudes.) These subjects averaged only 5.4 "yes" answers on the last page of the CMI. It is easy to see that the answers on this section could be influenced by the pressures and rigors of professional training. Three other students rated positive on all four of the CMI scoring criteria.

The female surgical patients in control Group 2 showed the highest overall anxiety score on the SDS, with a score of 42. There were 12 positive anxiety quotients in the surgical group, or nearly one-half of the patients. Only five of this group had a negative CMI rating, but an additional 11 had a positive score on the last page only. They averaged 5.2 "yes" answers on the last page. An additional nine had a positive score on all four of the CMI criteria. These nine also showed positive on the SDS.

In Group 3, only 12 of 50, or slightly under one-quarter of the patients, had a positive SDS. Of the 37 positive CMI questionnaires, again 17 were rated positive on the last page only. Of the 13 patients in Group 3 who had negative SDS and CMI combinations, ten had

TABLE 3. Summary of Study Results

Group	Average Age Years	Average SDS Score	Positive SDS Scores	CMI
1	23	34.8	52.5	(3 positive) (13 neg. scores) (13 pos. scores) (9 last page only) (3 positive all 4 criteria)
2 (Control)	42	42.0	47.1	(12 positive) (5 neg. scores) (20 pos. scores) 11 last page only (9 positive all 4 criteria)
3 (Study Group)	37	36.4	(12 positive)	(13 neg. scores) (37 pos. scores) (14 last page only) (23 all 4 pos.)

TABLE 2. Diagnosis of Validating Groups*

	Mean SDS Index	Range
Normal controls	33	25 - 43
Depressed (hospitalized)	74	63 - 90
*Depressed (outpatient)	64	50 - 78
*Anxiety reactions	53	40 - 68
*Personality disorders	53	42 - 68
*Transient situational adjustment reactions	53	38 - 68

demonstrable pathology. Arbitrarily, any urethral size over 24-French was considered a normal, anatomic, lower urinary tract. All bladder capacities were measured and considered normal, and no neurogenic bladders were found in this group. Of the negative SDS-positive CMI

TABLE 4. Summary of Results Related to Pathology in Group 3

No. of Patients	Demonstrable Pathology	No Demonstrable Pathology
Neg. SDS Neg. CMI		
13	10	3
Neg. SDS Pos. CMI Last page only		
14	11	3
Neg. SDS Pos. CMI (All 4 criteria)		
11	5	6
Pos. SDS Pos. CMI (All 4 criteria)		
12	2	10
Pos. SDS Neg. CMI		
None	0	0

patients, 11 of them showed pathology. In patients with all four criteria of the CMI rated positive, the number of patients with demonstrable pathology decreased significantly to only 7 out of 23. In this group, 12 patients

showed both a positive SDS and CMI, and only two of these had disease.

Conclusions

When used concurrently, SDS and CMI questionnaires can be of value to the urologist in sorting out functional overlay in the difficult-to-diagnose female patient. Depression alone, as measured by the SDS scale, does not appear to be a significant factor in this disease process. Those CMI questionnaires which are rated positive, based on four or more answers on the last page, probably are not significant in the assessment of functional overlay and may be considered as normals. If both the SDS and CMI scores are negative, then it would seem from these results, that a high yield of organic pathology should be expected. If both the SDS and CMI scores are positive, a high degree of functional overlay should be anticipated and considered in assessment of the patient. Between these two extremes lies a grey zone to which no particular diagnostic significance may be attached. These questionnaires are by no means diagnostic in themselves and are not 100-percent accurate, but they may supply important ancillary information that may aid in a correct diagnosis.

References

1. Brodman K, Erdmann AJ Jr, Lorge I, et al: The Cornell medical index: An adjunct to medical interview. *JAMA* 140:530-534, 1949.
2. Brodman K, Erdmann AJ Jr, Lorge I, et al: The Cornell medical index-health questionnaire, II. As a diagnostic instrument. *JAMA* 145:152-157, 1951.
3. Brodman K, Erdmann AJ Jr, Lorge I, et al: The Cornell medical index-health questionnaire, III. The evaluation of emotional disturbances. *J. Clin Psychol* 8:119-124, 1952.
4. Zung WW: A self-rating depression scale. *Arch Gen Psychiatry* 12:63-70, 1965.
5. Zung WW, Richards CB, Short MJ: Self-rating depression scale in an outpatient clinic. *Arch Gen Psychiatry* 13: 508-515, 1965.
6. Zung WW: Factors influencing the self-rating depression scale. *Arch Gen Psychiatry* 16:543-547, 1967.
7. Zung WW: Depression in the normal aged. *Psychosomatics* 8:287-292, 1967.

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EMERGENCY ROOM PHYSICIANS: Four-man Emergency Incorporated group seeking two additional full-time physicians. Negotiable salary plus paid liability insurance. Ohio license required. Positions open immediately. Please address resumes to: Necdet Orhon, M.D., 2066 Northridge Dr., Springfield, Ohio 45504, or call evenings 513/399-9663.

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SEPTEMBER 1976
Volume 72, Number 9

THE OHIO Medical Journal

STATE



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ILLINOIS PHYSICIAN COUNTERSUES
AND WINS, PAGES 516 AND 522

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SEP 20 1976

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Medical Hotline

Outstanding Response to Malpractice Suit Questionnaire

As of August 25, 1976, one fourth of the OSMA membership had responded to the Medical Malpractice Suit Questionnaire. This type of response indicates that the results of the survey will be very viable in combating the malpractice liability crisis facing Ohio physicians.

If you have not completed the questionnaire, please do so immediately. It appears in the August issues of both *The Journal* and the *OSMAgram*. The OSMA Task Force on Professional Liability desires that every Ohio physician be heard from by the time the final tabulations are made.

More Dollars Needed to Implement Malpractice Research Projects

Contributions to the Malpractice Research Fund now exceed \$200,000. This fund was initiated by the OSMA Task Force on Professional Liability to underwrite several projects designed to fight the malpractice liability crisis in Ohio. Do you number among the 2,000 plus physicians who have contributed?

The Malpractice Research Fund is currently supporting a five-point program:

1. **Counterclaim Research Project:** The OSMA legal counsel is studying the extent of the legal assistance which the OSMA could give the physician directly or through his legal counsel. A full report on the OSMA position will appear in the October issue of *The Journal*.

2. **Court Docket Survey:** This survey is now being pretested in Franklin County to determine the feasibility of conducting a survey statewide. In addition, OSMA members are asked to complete the Medical Malpractice Suit Questionnaire that appeared in the August issues of both *The Journal* and the *OSMAgram*.

3. **Physicians Insurance Company of Ohio:** After receiving House of Delegates' approval for formation, this company is in the development stage. See "Proceedings of the House of Delegates," page 543 of this issue.

4. **Actuarial Analysis:** Information from this study was used to challenge a 145-percent increase in malpractice insurance premiums filed by the Insurance Service Office. The filing was later withdrawn. It is estimated that this withdrawal has saved Ohio physicians \$1½ million per month.

5. **Public Education Campaign:** A survey of attitudes of Ohio residents toward the malpractice situation and medicine in general is underway. The results of the survey will be used in an intensive public education campaign to educate citizens on all aspects of the malpractice crisis.

Obviously, to most effectively carry out these proj-

ects, many dollars are needed. This type of funding entails the support of all OSMA members. The Task Force heartily thanks those physicians who have contributed their \$100 and asks others to join the cause today. Send your check to the OSMA Malpractice Research Fund, 600 S. High Street, Columbus, Ohio 43215. (Contributions are tax deductible in the same manner as OSMA dues).

The malpractice crisis affects every physician.

New Achievement by Hart Page, OSMA Executive Director

Hart F. Page, Executive Director of the OSMA, has been designated a Certified Association Executive by the American Society of Association Executives (ASAE). Mr. Page qualified for this certification by completing a personal data form listing his professional experience and by successfully passing an examination covering such association management subjects as law, education, and statistics. In addition to serving on the ASAE Board, Mr. Page will be Chairman of the ASAE Evaluation Committee for 1976-1977. Upon request, this committee will study and evaluate any ASAE member organization.

Join OMPAC in 1976 — Promote Quality Health Care

1976 is an election year. Physicians and their spouses should be politically active and should support the Ohio Medical Political Action Committee (OMPAC). OMPAC is dedicated to electing people to state and federal legislation positions who will promote quality health care in the U.S. regardless of political affiliation.

Ohio physicians interested in contributing money and/or time in the coming campaigns may contact their county society secretary or treasurer to volunteer. OMPAC dues may also be sent directly to the Ohio Medical Political Action Committee, P.O. Box 5617, Columbus, Ohio 43221. Regular memberships are \$35 and sustaining memberships are \$100. Physicians who are regular members may achieve sustaining status by sending an additional \$65. Spouses of members are encouraged to join OMPAC at a cost of \$15. OMPAC members automatically become American Medical Political Action Committee (AMPAC) members.

OSMA Publication for Patients

Is the OSMA's newest publication reaching your office? *Your Doctor Reports* is designed for the patient, and the OSMA asks that you place the monthly newspaper in your waiting room. If you do not receive the publication, contact Ms. Rebecca Doll, OSMA Manager of Media Relations, telephone: 614/228-6971.

A/New Jersey Flu Immunization Program Recap

The A/New Jersey Flu Immunization Program is scheduled to begin in Ohio during September. *The Journal* presents the following highlights so that Ohio physicians will be able to review the program before it commences:

Legal Authority

PL 94-266 signed by President Ford on April 13, 1976.

Liability Protection

S. 3735 signed by President Ford on August 12, 1976. Sec 2, B, (1): "To provide liability protection to the vaccine manufacturers and distributors who participate in the program, to the public and *private agencies* or organizations that participate in the program without charge for such vaccine or its administration, and to the *medical* and *paramedical personnel* who, without charge for such vaccine or its administration, administer or assist in administering inoculations under the program."

Program

The U.S. Government has contracted for the production of two types of "flu" vaccine from U.S. manufacturers: (1) **Bivalent**—Type A Victoria and New Jersey 76 (swine similar) and (2) **Monovalent**—Type A New Jersey 76 (swine similar).

Vaccine has only *killed virus*.

Distribution is through each state health department. Storage and delivery is the responsibility of the Ohio Department of Health. Each of the 88 Ohio counties has an approved program. Each designated Ohio county agency will distribute the vaccine to (1) private physicians and (2) public inoculation centers.

Influenza Virus

Type A: subtype Victoria, subtype New Jersey 76 (swine similar).

Type B: subtype Hong Kong (Asiatic).

Type C: does not involve humans.

Recommended Dosage

Age	Type Vaccine
1. Age 65 years and over (plus debilitating diseases*)	Bivalent A: Victoria and NJ 76 (swine)
2. Age 24 years and over	Monovalent A: NJ 76 (swine)—split vaccine is produced by manufacturers

3. Age 18-24 years	Same as above
4. Age 17 years and under	Undetermined

*Type B, Hong Kong Vaccine is available from one manufacturer under normal procurement (not government issue). This is recommended to physicians for their patients who may be exposed in the future to this type of flu. Both Victoria and Hong Kong type flu were prevalent in eastern and southeastern U.S. during 1975-1976.

OSMA Policy Statement

The OSMA policy regarding the immunization program is printed in the August 1976 issue of *The Journal* ("A/New Jersey Flu Immunization Program," Volume 72, No. 8, page 476). The OSMA Committee on Flu Immunization Program is providing continued monitoring and counsel.

Therapy

No specific therapy against the flu per se is available for patients who have "flu-like" reactions to inoculation or those who developed flu without prior protection.

The available antiviral preparations (ie, "amantadine hydrochloride") have potential benefits (*Journal of the American Medical Association*, Volume 235, No. 25, June 21, 1976, page 2739, "Prevention and Control of Influenza by Chemoprophylaxis and Chemotherapy").

The complications of this flu disease entity (ie, high fever, chills, pneumonia, heart failure, renal disease, dehydration) should be treated with the usual drugs, antibiotics, and chemotherapy available to the physician.

Informed Consent

Federal legislation requires the designated county agency to maintain for three years a properly signed informed consent. The form for the bivalent vaccine will be printed on blue paper and the monovalent on white paper.

This does not relieve the physician responsible for the administration of the individual inoculation from maintaining his own record of informed consent.

Surveillance

The Ohio Department of Health has in force at this time in specified areas an Influenza Surveillance System which is monitoring patients with suspected influenza or influenza-similar disease entities.

Dates

Each local designated county agency will announce during October and November the availability of vaccine, inoculation guns and syringes, and inoculation centers in its county. Local physicians can contact the county agency for vaccines to be given in physicians' offices.

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COVER: On August 1, 1976, the OSMA House of Delegates authorized the formation of a medical professional liability insurance company to be owned by the OSMA and the physicians of Ohio. The Physicians Insurance Company of Ohio (PICO) is now in the development stage. Joseph K. Gilmore of the Ohio Department of Insurance has been appointed president of the new company. See "Proceedings of the House of Delegates," page 543, for details.

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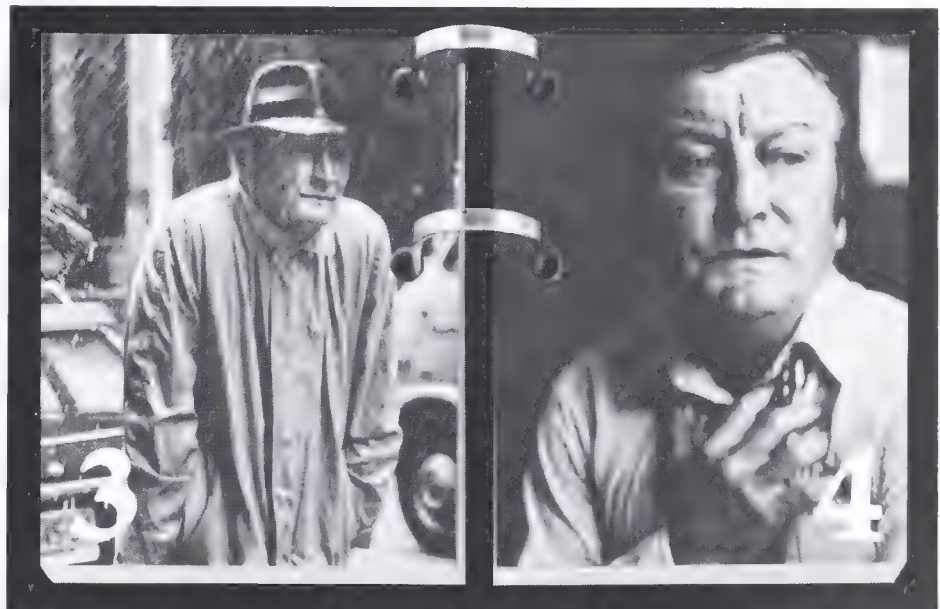
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1. Russek HI: AM J M Sc 239:478, 1960



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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchism, 30 mg. **REFERENCE:** Robert * B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Vitamin B-12	1.5 mcg

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Zinc (from Zinc Oxide)	0.25 mg
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A regular meeting of the Council of the Ohio State Medical Association was held Saturday, July 10, and Sunday, July 11, 1976, at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Drs. Stewart B. Dunsker, W. J. Lewis and Richard E. Hartle); Drs. P. John Robechek, Cleveland, Chairman, Ohio Delegation to the AMA; John H. Budd, Cleveland, President-Elect of the AMA; Neal N. Earley, Cincinnati, President, Academy of Medicine of Cincinnati; Mr. William J. Galligan, Cincinnati, Executive Secretary, Academy of Medicine of Cincinnati; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Freeman, Mrs. Wisse, Mrs. Dodson, Mrs. Jacobson and Ms. Doll, of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Dr. Hartle); Drs. Robechek and Budd; Mr. Pohlman; Dr. H. William Porterfield, Columbus, President, Ohio Foundation for Medical Care; Dr. James L. Henry, Grove City, Chairman, Task Force on Professional Liability; Thomas C. Coady, Esq., Columbus, Legal Counsel; Mr. Thomas M. Quilter, Columbus, Executive Director, Ohio Foundation for Medical Care; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Holcomb, Freeman, Mrs. Wisse, Mrs. Dodson, and Mrs. Jacobson, of the OSMA Staff.

AMA PRESIDENT-ELECT WELCOMED

Dr. Bates welcomed Dr. John H. Budd, President-Elect of the American Medical Association, who attended the entire meeting of the Council. Dr. Budd received the applause and congratulations of the Council.

SPECIAL SESSION OF THE HOUSE

The President announced that arrangements have been completed for the special meeting of the OSMA House of Delegates, called by official action of the Council for August 1, 1976. The place of the meeting will be the Sheraton-Columbus Hotel.

MINUTES APPROVED

The minutes of the April 28 and May 13, 1976, meetings of the Council **were approved**.

The minutes of a June 3, 1976, meeting of Council, held by conference call, were ratified and affirmed. This meeting resulted in the unanimous approval of a contract with Management Horizons, Inc., for services to

be performed in connection with research and development on the OSMA professional liability insurance program.

Also **approved** during the June 3 meeting was the institution of legal procedures in the Franklin County Common Pleas Court challenging the 145 percent professional liability insurance rate increase filed by the Insurance Service Organization.

The minutes of a meeting of Council on June 29, 1976, also held by conference call were ratified and affirmed, which **approved** the following recommendations of the Task Force on Professional Liability:

(1) "That a professional liability insurance company be formed to provide the Ohio State Medical Association membership with an alternative source of professional liability insurance."

(2) "That the proposed professional liability insurance company be a for-profit stock company (subject to willingness to reconsider)."

(3) "That the Council authorize the Task Force to proceed with preparation for implementation."

In addition, the Council, on June 29, **approved** the President's recommendation that a special session of the OSMA House of Delegates be called for 10:00 AM, August 1, 1976, at Columbus, Ohio, for the purposes (a) "To fulfill the wishes of the House which requested 'that the Ohio State Medical Association Council continue to research the feasibility of forming a health care provider-owned insurance company and report their recommendations to the House of Delegates as soon as possible,'" and (b) "To report to the House of Delegates on Countersuit activities, in keeping with the House's request that Council actively develop and sponsor legislation and procedural rules which would allow that a countersuit for damages for abuse of process in filing such an action be filed and litigated in the same action."

The Council also endorsed in concept at that time HR 14569, the AMA-sponsored bill in Congress to seek immunity or indemnification to protect physicians involved in mass immunization campaigns of the A/New Jersey ("Swine Flu") Influenza Immunization program.

MEMBERSHIP

Membership statistics were presented by Mr. Page. He pointed out that membership in OSMA, as of June 30, was 400 above the same date in 1975.

Problems of declining AMA membership in Ohio were discussed. The Membership Department was asked to proceed at once with its campaign to bring to the attention of Ohio physicians the advantages of membership in the American Medical Association.

(continued on page 510)

FIRST DISTRICT CHANGE

The written resignation of Stewart B. Dunsker, M.D., the First District Councilor, was received and was accepted by the Council.

On motion duly made and seconded, the Council, acting under the authority granted in Section 7, Chapter 7, of the OSMA Bylaws, and in accordance with a specific request from the Caucus of the First District, appointed Stephen P. Hogg, M.D., to fill the vacancy created by Dr. Dunsker's resignation.

FISCAL MATTERS

The minutes of a meeting of the Auditing and Appropriations Committee held July 9, 1976, were presented by Dr. Rinderknecht and were approved as presented.

AMERICAN MEDICAL ASSOCIATION

Dr. P. John Robechek, Chairman, Ohio Delegation to the AMA, reported on the AMA House of Delegates session, held June 26-July 1, 1976, in Dallas, Texas. His remarks were supplemented by Dr. John H. Budd.

The Council complimented Dr. Robechek; Dr. Oscar W. Clarke, Elections and Candidate Chairman of the Delegation; the remainder of the John Budd, M.D., Campaign Committee, Dr. B. Leslie Huffman and Dr. W. J. Lewis; and the entire Ohio Delegation to the AMA on the successful campaign to elect Dr. Budd as President-Elect of the American Medical Association.

The Council voted that the AMA Delegation and OSMA staff continue the OSMA-Columbus Academy of Medicine campaign for the selection of Dr. Robert M. Zollinger, Columbus, as next year's recipient of the Sheen Award of the American Medical Association.

OSMA HOUSE OF DELEGATES RESOLUTIONS

The resolutions passed by the 1976 OSMA House of Delegates were referred by the Council as follows:

Resolution	Subject	Referred to	Resolution	Subject	Referred to
Am. Res. 1-76	Parliamentarian	OSMA Council	Am. Res. 18-76	Professional Liability/Occurrence Contracts	Task Force on Professional Liability
Am. Res. 4-76	Advertising	OSMA Council	Am. Res. 20-76	Professional Liability/Arbitration	Task Force on Professional Liability
Am. Sub. Res. 6-76	Professional Liability/Legal Redress	Task Force on Professional Liability	Sub. Res. 21-76	Professional Liability/Data	Task Force on Professional Liability
Am. Res. 7-76	Confidentiality	OSMA Legal Counsel	Am. Sub. Res. 23-76	Hospital Discharge Data	Committee on Government Medical Care Programs (Resolution adopted by June 1976, AMA House).
Am. Res. 8-76	Professional Liability/Insurance Company	Task Force on Professional Liability	Am. Sub. Res. 24-76	Direct Billing	Committee on Government Medical Care Programs (Resolution adopted by June 1976, AMA House).
Am. Res. 9-76	Professional Liability/Stabilization Reserve Fund	Task Force on Professional Liability	Am. Sub. Res. 25-76	PSRO	Committee on Government Medical Care Programs
Res. 10-76	Professional Liability/JUA	Task Force on Professional Liability			
Am. Res. 14-76	Smoking Ban in Hospitals	OSMA Staff			
Res. 15-76	Public Law 93-641	Council and Department on Federal Legislation			
Am. Res. 16-76	Medical Federation	AMA Delegation			
Am. Res. 17-76	Professional Liability/Consent to Settlements	Task Force on Professional Liability			

MAI/PEER REVIEW SYSTEMS

A letter from Joseph L. Bitzan, M.D., was referred to Medical Advances Institute.

Dr. Henry discussed the Ohio Health Data Corporation. It was indicated that a final draft of the structure of the Corporation will be available in advance of the September Council meeting.

OHIO MEDICAL INDEMNITY, INC.

A report on recent meetings of the Executive Committee and Board of Directors of Ohio Medical Indemnity, Inc., was presented by Mr. Gillen.

(continued on page 512)

Resolution	Subject	Referred to
Am. Res. 27-76	The Patient Speaks	OSMA Staff
Am. Res. 30-76	Professional Liability/Sliding Scale Premiums	Task Force on Professional Liability
Res. 32-76	Commending Richard Meiling, M.D.	Notify Dr. Meiling
Sub. Res. 33-76	Culture Committee	OSMA Council
Res. 34-76	Physician Registration	OSMA Membership Department
Res. 35-76	Citizenship Requirements	Copy to staff for Bylaws revision
Am. Res. 37-76	Congratulations to AMA	Communication from President to AMA
Res. 40-76	Determination of Death	Department of State Legislation
Am. Res. 42-76	Maximum Allowable Cost Regulations	Committee on Government Medical Care Programs
Sub. Res. 45-76	Professional Liability/Solicitation	Task Force on Professional Liability
Am. Res. 47-76	Nomination and Election of District Councilors	Staff for Bylaws revision

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OHIO FOUNDATION FOR MEDICAL CARE

Dr. H. William Porterfield, President of the Ohio Foundation for Medical Care, addressed the Council regarding the role and activities of the Foundation.

The Council meeting was adjourned, and a meeting of the administrative members of the Ohio Foundation was convened.

Subsequently, the meeting of the administrative members of the Foundation was adjourned and the Council meeting was reconvened.

COMMITTEE REPORTS

COMMISSION ON MEDICAL EDUCATION

The Council discussed a letter from Dr. Howard S. Madigan, Chairman, OSMA Commission on Medical Education. In accordance with his suggestions, the Council voted to add the President of the Ohio Academy of Family Practice (or his designee) and a member of the Ohio State Medical Board to the Commission.

The minutes of the April 7, 1976, and the June 16, 1976, meetings of the Commission were presented by Mr. Houser.

At the April 7 meeting, 20 Physician Recognition Awards were presented, and the USAF Medical Center, Wright-Patterson Air Force Base, was given a two-year provisional accreditation.

The Committee recommended, and the Council **approved**, the concept that *The Journal* section on "Continuing Education Courses for Physicians" list only those courses approved for Category I.

The fees for the OSMA Physician's Recognition Award were reduced, and the new schedule is as follows:

AMA/OSMA Member	\$ 5
OSMA Member but not AMA	\$30
(if OSMA member wishes not to receive AMA award, cost will be \$5)	
AMA Member but not OSMA	\$10
Member of Neither	\$35

At the June 16 meeting, three physicians received the 1975 award and five the 1976 award.

Community Memorial Hospital, Marion, received a two-year provisional accreditation; and Mt. Carmel Medical Center, Columbus, received four-year accreditation.

The minutes, as a whole, were **approved**.

COMMITTEE ON EMERGENCY AND DISASTER MEDICAL CARE

The minutes of the Committee on Emergency and Disaster Medical Care meetings of March 6 and June 12, 1976, were presented by Mr. Houser.

Support in essence of legislation to set standards for the teaching of emergency medical technicians and specifying liability for emergency medical services was included. Also supported in concept was legislation providing for the regulation of ambulances and ambulance personnel.

With regard to emergency medical identification, the Council **approved** the Committee suggestion that OSMA endorse the concept of these devices, but the type to be used be selected by the individual or his physician.

The March 6 minutes were **approved**, and the June 12 minutes were accepted for information.

COMMITTEE ON MEMBERSHIP AND PLANNING

The minutes of the March 20, 1976, meeting of the Committee on Membership and Planning were presented by Mr. Gillen and were accepted.

COMMITTEE ON MENTAL HEALTH

The minutes of the April 4, 1976, meeting of the Committee on Mental Health were presented by Mr. Clinger.

The Council **approved** the Committee's recommendation to oppose legislation in the U.S. House and Senate which would extend federal regulatory power from its present concern with the pharmaceutical industry to the prescribing of drugs in the practice of medicine by physicians. (SB 2697 /Kennedy-Javits/ and HR 11617 /Rogers/).

Also **approved** was the Committee's recommendation that the Association recommend to the Federal Food and Drug Administration that it form an advisory panel made up of **practitioners** who are knowledgeable on the day-to-day aspects of drug prescribing by the physician and drug use by the patient.

The Council **approved** Committee recommendations that the OSMA consider legislation to unclassify from Civil Service, all physicians in the employ of the State of Ohio.

Six recommendations concerning the Physician Effectiveness Program were received by the Council.

The minutes, as a whole, were accepted.

COMMITTEE ON PRIVATE PRACTICE

The minutes of the April 13, 1976, meeting of the Committee on Private Practice were presented by Mr. Edgar.

(continued on page 514)

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The Council amended, by substitution of new language for paragraph 2, and **approved** the following with regard to Public Law 93-641.

1. Arrange for OSMA spokesmen to discuss with all candidates for the U.S. House of Representatives and the U.S. Senate, the many adverse effects of PL 93-641 and possible repeal of the law.

2. Urge County Medical Societies to observe closely the planning activities of Health Service Agencies in order that accurate medical information is utilized as the basis for health planning.

3. Ask the County Medical Societies to report to their members, to the public, and to the Ohio State Medical Association, detailed accounts of their independent planning activities, findings, and recommendations.

4. Actively support and urge all other State Medical Associations to support the AMA in its opposition to PL 93-641.

The minutes, as a whole, were accepted.

JOINT ADVISORY COMMITTEE ON SPORTS MEDICINE

The minutes of the May 11, 1976, meeting of the Joint Advisory Committee on Sports Medicine, were presented by Mr. Clinger.

The Council **approved** a recommendation of the Committee that its policy of September 1970, be reaffirmed and that the OSMA give active support to current efforts for certification for interscholastic athletic

coaches, with certification standards to include medical aspects of sports in the overall curriculum.

The remainder of the report was received for information.

COMMITTEE ON PRISONS AND JAILS

The minutes of the June 16, 1976, meeting of the Committee on Prisons and Jails were presented by Mr. Gillen and were received for information.

THOMAS E. RARDIN FAMILY PRACTICE SCHOLARSHIP SUBCOMMITTEE

The minutes of the June 16, 1976, meeting of the Thomas E. Rardin Family Practice Scholarship Subcommittee were presented by Mr. Clinger.

He announced that the Subcommittee selected G. William Courtright, II, of Mt. Vernon, and Ms. Elizabeth J. Schreiner, of Hinckley, to receive the 1976 scholarships.

The minutes were accepted for information.

1973 MATERNAL MORTALITY REPORT FOR OHIO

The 1973 Maternal Mortality Report for Ohio was submitted by the OSMA Committee on Maternal Health and **was approved** with commendation.



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A/NEW JERSEY INFLUENZA (SWINE FLU) IMMUNIZATION PROGRAM

Mr. Clinger reported the minutes of the Ad Hoc Advisory Committee on A/New Jersey Influenza Immunization Program, which met July 7, 1976.

The Council then adopted a policy statement on the program (see *The Journal*, Volume 72, No. 8, page 476, "A/New Jersey Flu Immunization Program").

COUNCILOR REPORTS

The Councilors reported on activities within their districts.

FEDERAL LEGISLATION

Mr. Edgar reported on the success of the Beall-Taft-Bentsen amendment to the health manpower bill, removing the federal residency control feature in federal aid to medical education.

He also reported on Senate Bill 3205, Talmadge, the Medicare-Medicaid Administrative and Reimbursement Reform Bill.

The Council voted active opposition to this measure.

CONSTITUTION AND BYLAW AMENDMENTS

The Council authorized the appointment of an Ad Hoc Committee to study the OSMA Bylaws with respect to Councilor election and appointment procedures. Dr. Bates appointed Dr. Pichette, chairman, and Drs. Diller and Williams.

The Council voted to drop citizenship requirements from the county medical society "model bylaws."

The Articles of Incorporation of the Stark County Medical Society **were approved** contingent upon the inclusion of minor amendments suggested by legal counsel.

Amendments to the Lorain County Medical Society Constitution and Bylaws **were approved** subject to deletion of minor phrases to bring the document into conformity.

Amendments to the Ashtabula, Belmont, and Crawford County Medical Societies' Constitution and Bylaws **were approved** subject to conformance by the deletion of citizenship requirements.

FIELD SERVICE REPORT

The Council received a report on the operation of the Field Service from Mr. Holcomb.

It was requested that the Field Service bring to the Council, in September, a specific proposal for a seminar on negotiations.

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OHIO STATE MEDICAL JOURNAL

Two changes in format for *The Ohio State Medical Journal* were submitted by Mrs. Jacobson and **were approved**. The new areas include material on pharmacology from the medical schools and monthly columns on the various specialties, designed for readership of the primary care physician.

OBESITY BYPASS

A file regarding the use of guidelines governing bypass procedures for obesity was received by the Council.

MERGER OF INSURANCE PLANS

A merger of the Academy of Medicine of Cincinnati and the Ohio State Medical Association Group Term Life Insurance Plans **was approved** by the Council.

MEDICAL SERVICE REVIEW STUDY SEPTEMBER DOCKET

It was the expressed intention of the Council to re-evaluate medical service review procedures at the September meeting of the Council in light of a recent decision, *Anderson v. Medical Service of the District of Columbia*, which was handed down by the United States District Court for the Eastern District of Virginia.

Adjourned.

ATTEST: Hart F. Page
Executive Director

Doctor Finds New Cure for Malpractice Suits

Wayne B. Giampietro, Esq./Chicago

EDITOR'S NOTE: The following article is reprinted from the *Illinois Medical Journal*, Volume 150, Number 1 (July 1976). The article discusses a successful countersuit filed by an Illinois physician, Leonard Berlin, M.D. Following this article is an editorial written by Dr. Berlin concerning his suit (page 522). This editorial is also reprinted from the *Illinois Medical Journal*, Volume 150, Number 2 (August 1976).

Currently, OSMA staff and legal counsel are researching the area of countersuits in Ohio. They are preparing a program for the OSMA with regard to countersuits. Details of this program will be printed in the October issue of *The Journal*.

"Every person shall find a certain remedy in the laws for all injuries and wrongs which he receives to his person, privacy, property or reputation. He shall obtain justice by the law, freely, completely, and promptly." Constitution of the State of Illinois, Article I §12

Dr. Leonard Berlin had been wronged. He seethed inwardly. He was not about to take it lying down. So he did something about it, and became the first doctor in memory to successfully carry a suit against a patient and attorneys to a favorable jury verdict for filing an unfounded medical malpractice suit against him. While similar success cannot be guaranteed for every doctor who prevails in a medical negligence suit brought against him, his victory signals that the more outrageous of those suits will be curtailed drastically. Doctors are no longer helpless in the face of the seemingly uncontrolled rise of such suits. This landmark verdict shows that courts and juries are willing to listen carefully to the complaints of medical men that they are being wronged in many instances, and ready to compensate them for damage which is needlessly inflicted upon them.

Scenario

This story starts routinely enough. Dr. Berlin, radiologist at a suburban Chicago hospital, was surprised when Harriet, one of his neighbors, with whom he had a slight acquaintance, appeared in the waiting room of his hospital on October 1, 1973. Upon learning that she had injured her right little finger playing tennis, Dr. Berlin directed the laboratory technicians to take the necessary X-rays with as much dispatch as possible. He immediately read the X-rays, and diagnosed a dislocation of the finger.

Harriet was then directed to the emergency room where noted orthopedist, Dr. William Meltzer, concurring in the diagnosis, reduced the dislocation and applied a splint, directing her to return for follow-up examination within a week.

Harriet did not return to Dr. Meltzer within that period of time, but approximately three weeks later appeared at the office of Dr. Meltzer's partner. Additional X-rays were taken at that time, which disclosed a small chip-fracture at the base of the middle phalanx of her right little finger.

Dr. Berlin never saw Harriet again in connection with this matter, and had nothing more to do with the treatment of her injury. Thus, he was stunned to receive a call a year-and-a-half later from Harriet's husband, Gilbert, an attorney, stating that he was making a "courtesy" call to inform him that they were considering suing Dr. Meltzer for malpractice and would have to include Dr. Berlin as a defendant since he had read the original X-rays. Gilbert's main complaint was that the orthopedist had not taken his wife's injury seriously, was abrupt and too fast. What really made him angry was that a cousin of his had attempted to call the orthopedist for information about the treatment and had been "given a run around" and couldn't get to first base. Dr. Berlin vainly attempted to explain that even if the fracture could have been seen and diagnosed initially, the treatment would have been exactly the same and that any continuing disability on Harriet's part was due to the injury caused by the tennis accident, not the treatment given. Dr. Berlin continued that regardless of any complaint about the orthopedist this was no reason to involve him, and that as a fellow professional he ought to be aware of the ridiculousness of the charge he was making. Gilbert remained adamant, however, stating that if his wife's finger did not improve, he would have to take legal action.

Dr. Berlin, of course, began to make inquiries, and discovered that Harriet had subsequently seen another orthopedist for consultation, who had written a report of his findings, a copy of which he had sent to Dr. Meltzer, who in turn provided a copy to Dr. Berlin.

It did not come as a complete shock to Dr. Berlin, then, when he was served with a summons and complaint eight months later. What did shock him, however, were the charges which were made against him in the malpractice complaint. In addition to being charged with having failed to diagnose the fracture, he was accused also of: failing to X-ray all necessary views of the injured finger; wrongfully diagnosing a dislocation causing Har-

riety to sustain improper treatment; failing to let the X-rays dry long enough to obtain a clear picture before reading them; and that he had been "otherwise careless and negligent."

Reading this complaint was the last straw. While the charge that he had failed to discover the fracture was not entirely unexpected, the other accusations were totally without foundation. What is more, there was no possible basis for them. Neither Harriet, Gilbert, nor her attorneys could have had any information which would support them.

Alternatives

Dr. Berlin decided to counter-attack. He, along with most medical men, had been alarmed by the rising tide of malpractice claims, some totally without foundation, and many of which while containing at least arguably valid claims, named all medical personnel who had come into contact with the patient at any time. While his liability insurance carrier had provided him with excellent defense counsel, who assured him that the claim would undoubtedly not stand up and would almost surely never come to trial, Dr. Berlin was not satisfied. He was not content to let the matter drag on for years, with the possibility that the insurance carrier would decide to pay a nuisance amount to get rid of the case because doing so would cost less than trying the case to a verdict.

Along with some attorney friends, he sat down to devise a method to bring the subject of frivolous and unfounded claims into the open. While causes of action for malicious prosecution and abuse of process are well-recognized in Illinois and other states, such a suit cannot be commenced until the prior litigation has been concluded in favor of the wronged defendant. To wait two or three years until the conclusion of the malpractice suit was not what they had in mind. They wanted to bring the grievance to a head immediately. So they devised a novel theory, charging Harriet, her husband, Gilbert, and the attorneys with willful and wanton misconduct—a reckless disregard of Dr. Berlin's rights. This suit was filed as a separate and independent action, but was subsequently consolidated with the malpractice suit, to be tried before the same judge. Indeed, the cases were set to be tried together, the malpractice suit as the main claim, Dr. Berlin's suit as a counterclaim—to be heard and determined by the same jury. However, that was not to come to pass.

Response

The initial reaction to Dr. Berlin's suit was somewhat in the nature of tolerant amusement. Predictions were that it would be dismissed immediately. The tables were soon to turn, however. The doctor's suit was not dismissed. It was subsequently amended to add another count, against the attorneys only, charging them with having filed Harriet's suit without a reasonable basis or cause, thereby falling below the standards required of attorneys to perform their professional duties in good faith, or in other words, being negligent. The complaint withstood

attacks that it did not state a legal claim, and both cases were set for trial. Suddenly, on the very morning that the trial was to start, Harriet's attorney announced to the Court that she was dismissing her suit on her own initiative, with prejudice, meaning that it could never be filed again. While urged by many that he had been fully vindicated, and ought to likewise dismiss his suit, Dr. Berlin refused, and insisted on having his jury trial.

At Issue

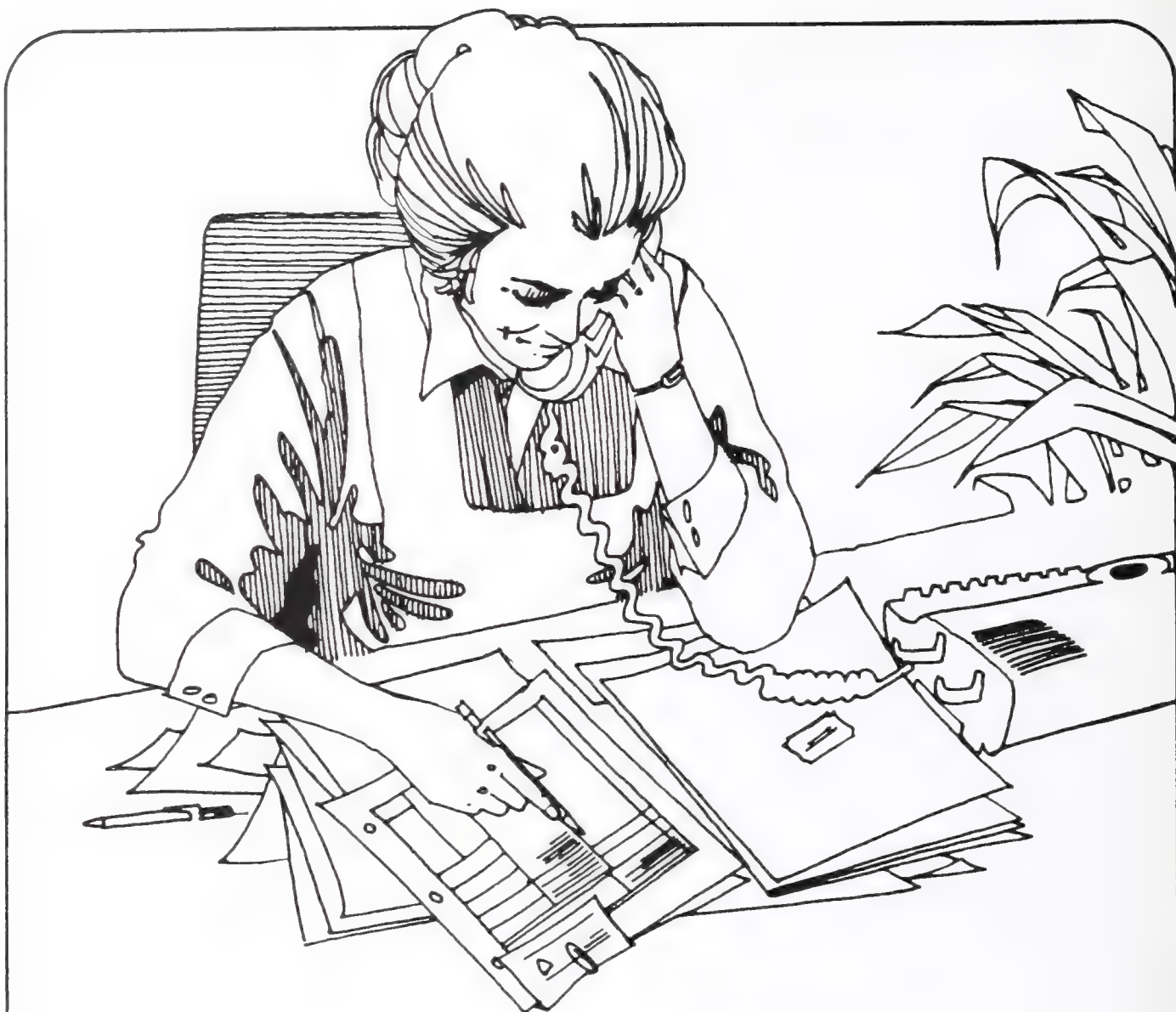
Trial lasted three days. Predictions were that while he had a good chance of prevailing against Harriet, and perhaps Gilbert as well, he would most probably not be successful against her attorneys. Instead, the jury returned a verdict awarding Dr. Berlin \$2,000.00 actual damages and \$6,000.00 punitive damages jointly against all defendants.

The trial itself was ordinary in many respects. Dr. Berlin and Dr. Meltzer testified to the treatment which they had given Harriet and its propriety. No one was produced by the defendants to counter this testimony.

The evidence of the defendants' actions, however, was devastating. Harriet first contacted an attorney, other than her husband, little more than a month before the statute of limitations was due to expire, at which time only preliminary discussions were held. On September 8, 1975, she delivered to her attorneys a written statement, prepared by her, the letter from the last orthopedist whom she had seen, dated nearly a year previously, the emergency room report of the treating orthopedist, and copies of Dr. Berlin's written report of his findings upon viewing the X-rays taken of her finger nearly two years previously. Echoing the statements of Gilbert to Dr. Berlin, she stated that the treating physician's attitude was extremely casual and offhand, and that he had dismissed the incident as trivial and unimportant. While she reported that she had been told to return within 10 days of the original injury, she failed to state that she had not returned to see any physician for three weeks. She made several allegations as to what subsequent doctors she had seen stated to her which were flatly denied by those doctors at the trial:

1. She had not suffered a dislocation of her finger;
2. Certain required angles were not taken in the X-rays;
3. The original splint had been placed incorrectly on her finger;
4. The presence of the bone fragment from the chip fracture at least partially caused her the loss of the use of her finger;
5. All of the X-rays taken, including the original ones before any treatment was given, showed the fracture;
6. Her injury had been treated too lightly;
7. If another of the orthopedists had treated her originally he would probably have performed surgery immediately, but could not do so by the time she came to him;

(continued on page 519)



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Doctor Finds Malpractice Cure (continued from page 517)

8. The condition of her finger, being permanently bent, stiff and sore, was totally unnecessary and could have been prevented if proper and prudent care had been administered to her at the time of the accident.

The attorneys who decided to take her case did not know at the time that these doctors would deny all of these statements, because they made *no attempt whatsoever* to contact either of the two doctors she claimed had made these statements attributing malpractice to Drs. Berlin and Meltzer. Instead, they immediately drafted a complaint and filed it three days after receiving the statement. They admitted at the trial that at the time they drafted and filed it, they had no basis for stating that Dr. Berlin had failed to take the proper views of the finger, wrongfully diagnosed a dislocation, failed to let the X-rays dry long enough, and had been otherwise careless and negligent. These allegations were explained at the trial as being the usual claims made in a medical negligence case, which could be dropped from the suit if subsequent discovery proved them to be unfounded.

An Attorney's Duty

However, as forcefully brought out at the trial by the legal experts who testified on behalf of Dr. Berlin, there were certain indications in the material which Harriet presented to them which should have put any reasonable attorney on notice that many of her allegations were not correct. The letter from the subsequent treating orthopedist when read in its entirety gave no hint that any improper treatment had been given to Harriet by prior doctors. Rather than supporting her claim that her finger was totally stiff and bent and unusable, the letter indicated that she in fact had considerable freedom of movement in it, which improved significantly between the first and second time she visited him, about six weeks apart. Most importantly, however, his letter flatly contradicted her statement that all of the X-rays disclosed the chip fracture, clearly stating that only those taken three weeks subsequent to the injury showed it. It was the testimony of these experts that these obvious discrepancies between her story and the report of this physician should have caused any prudent attorney, exercising the usual skill and prudence in the community, to conduct at least an initial investigation into her allegations. They pointed out that even though time for filing the suit was short, some attempt should have been made to contact the doctor who had written the report which she tendered. In their opinion, the failure to take this clearly indicated step was negligence on the part of the attorneys.

Their opinion was based upon the duty which an attorney owes: 1) not to involve a client in frivolous and unfruitful litigation; 2) not to burden the courts with unfounded claims; 3) not to make an allegation against an opposing party without some reasonable cause to believe that there is some basis for it, particularly if it might harm his professional standing and reputation;

and finally 4) not to harm his own reputation by advancing frivolous and unfounded litigation. Several disciplinary rules and ethical considerations as set forth by the American Bar Association were relied upon in reaching these conclusions, among which are:

A lawyer should not handle a matter without adequate preparation;

A lawyer is not justified in asserting a frivolous position;

A lawyer must treat with consideration all persons involved in the legal process and to avoid the infliction of needless harm;

A lawyer should not file a suit when he knows or it is obvious that such action would serve merely to harass or maliciously injure another.

Obviously, the fact that members of the legal profession were willing to take the witness stand and testify under oath that fellow-attorneys had not acted with the proper care and expertise was critical to the conclusion reached by the jury. Had it not been for the willingness of such men to step forward, the likelihood that the attorneys would have been held liable in this case would have been lessened considerably. Without such testimony there is little doubt that they would not have been found liable along with Harriet and Gilbert.

As for Harriet and Gilbert themselves, their testimony during the trial was truly their own undoing. It became obvious that the charge that subsequent doctors had been critical of the treatment initially given her was their opinion alone. They were the ones who stated to the third doctor whom they consulted, that the second doctor had been critical of the first. They then, in turn, told the second doctor, that the third had been critical of the first. Both doctors denied that they had ever made any such statement or had even implied any such criticism.

The eagerness of Gilbert to insulate himself from any liability for the actions of his wife and her attorneys obviously led the jury to discredit most of his testimony, as well as much of his wife's. He claimed that he had never spoken to Harriet's attorneys about the filing of a suit on behalf of his wife. Yet, it was he who had obtained what records were given to them, personally delivered them to their offices, placing on top a note requesting that he be allowed to review the complaint in his wife's case before it was filed. It was also he who had written, on his law office letterhead, to the doctor, requesting the written report on the condition of his wife's finger.

His testimony, echoed by his wife, that the two of them had never discussed between themselves the filing of a malpractice suit by her, was simply not believed by the jury. Nor was Harriet believed when she testified that she was unaware that a written report had been prepared by the consultant or requested by her husband. It is surely this absolutely unbelievable testimony which went a long way toward convincing the jury to award to Dr. Berlin \$6,000.00 in punitive damages.

(continued on page 520)

Doctor Finds Cure (continued)

When the jury signalled that it had a verdict less than an hour after the case had been submitted to it for deliberation, there was some concern in Dr. Berlin's camp. Normally, when a jury returns a verdict quickly, it is a sign that its decision is in favor of the defendant, on the theory that a short period of deliberation signifies that the jurors have not had time to deliberate upon the amount of damages. Everyone in the courtroom was amazed when the jury verdict was opened and read, awarding \$2,000.00 actual damages and \$6,000.00 punitive damages. Not the least amazed was Dr. Berlin's attorneys, who had only requested the jury to return a total verdict in favor of his client for \$3,000.00 (\$1,000.00 actual and \$2,000.00 punitive).

Reactions

Dr. Berlin had set out to prove a point. He was not seeking any substantial amount of damages, for his actual losses had been little, consisting mostly of time spent preparing to defend the suit brought against him. He was not motivated by any vindictiveness against the defendants he had named. That he proved his point even better than he had expected was doubly gratifying.

Even more surprising was the public reaction to the result. While he and his attorney were aware that there was considerable interest in the case, neither of them was prepared for the actual reaction from the medical profession, the news media, and even from the legal profession. Almost without exception, the reaction to this case has been favorable on all of these fronts. Everyone realizes that while there are indeed legitimate complaints of medical negligence, great abuses have arisen in the area. It is not the legitimate cases of malpractice (even those where large verdicts or settlements have been awarded) which have caused a fantastic upward spiral in medical liability insurance, but the plethora of small "nickel and dime" cases, which cost nearly as much to investigate and defend. The result in Dr. Berlin's case is a heartening indication that the legal system does and can work to the advantage of everyone, including the medical profession, if they will but utilize it properly.

This, of course, is not to say that every doctor who is named as a defendant in a malpractice case is entitled to recover as Dr. Berlin has, or should file a similar countersuit. As was so graphically demonstrated in this case, before a suit of any kind is filed, you must be sure of your facts. If an attorney or doctor is seriously considering filing such a claim, he must investigate his proposed cause of action to as great a degree as he would expect his opponent to have investigated his. The rules are the same for all—frivolous or unfounded allegations may well subject the ones propounding them to money damages.

The moral to be gained from this case is much broader than the specific fact situation involved here. The courts are open to everyone. Anyone is free to file a suit

(continued on page 527)

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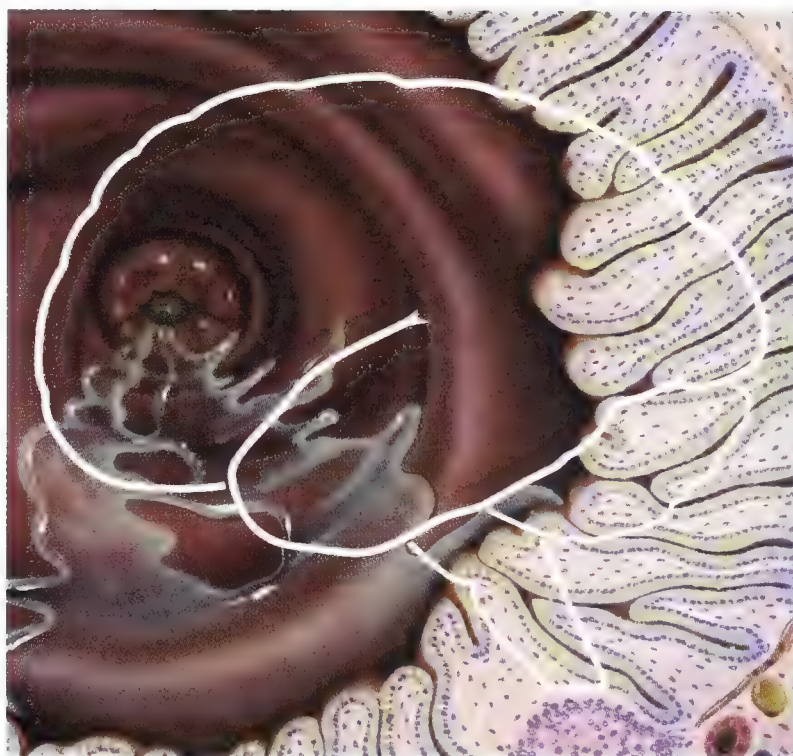


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A Time to Countersue

Leonard Berlin, M.D., Skokie, Illinois

EDITOR'S NOTE: The following article is reprinted from the *Illinois Medical Journal*, Volume 150, No. 2 (August 1976). Dr. Berlin's countersuit is the subject of the article "Doctor Finds New Cure for Malpractice Suits," page 516 of this issue of *The Journal*.

"To every thing there is a season, and a time to every purpose. . . :

A time to be born, and a time to die;

A time to plant, and a time to pluck up that which is purpose. . . :

A time to kill, and a time to heal;

A time to break down, and a time to build up;

A time to weep, and a time to laugh;

A time to mourn, and a time to dance; . . .

A time to seek, and a time to lose; . . .

A time to keep silence, and a time to speak;

A time to love, and a time to hate;

A time for war, and a time for peace."

Ecclesiastes, 3:2-8

. . . And may I add, "A time to be sued, and a time to countersue!"

The system of government and law in our country is based on precepts of checks and balances. Every citizen in our society, whether acting as an individual or as a member of a group, must answer for personal actions—one must be accountable. Each of us—doctors, accountants, professors, blue collar workers, working people of all types—must abide by certain standards imposed upon us by our society. This includes lawyers.

Lawyers seem to have had their own way in malpractice litigation for many years. They have made the rules, have determined guidelines of practice, and have escaped many checks or balances. Until now, that is. In malpractice cases, they have arbitrarily and unilaterally determined that a physician can be sued with very little if any cause, with immunity, and seemingly without penalty if it is found that there was no justifiable reason. Many lawyers have determined to allow a client to sue a physician alleging malpractice, even if that physician had little if anything to do with the claimed act of malpractice, because either the physician could then be forced to supply valuable testimony or because an insurance carrier would supply additional funds from which the suing attorney could draw. Lawyers have decided who will be sued and for what reasons. And they have to answer to no one for these decisions.

There was a time for that type of practice. But that time has passed. Today those practices can be interpreted

as abuses—abuses that we can no longer tolerate. Today the cost of medical care has increased to such an extent that it has created a crisis. People are beginning to realize that much of this cost is directly due to the malpractice insurance premiums. They are beginning to learn that premiums are so high because there are too many frivolous malpractice suits filed and because even when a legitimate suit is filed, there are too many doctors named frivolously as co-defendants. People also are beginning to find out that when a doctor is simply named as a co-defendant in a suit, it costs his insurance carrier an average of \$2,500 in legal costs to just "open the file" in the case. They are beginning to understand that if an insurance company decides to defend a doctor in a suit, it can cost anywhere between \$5,000 and \$15,000, and up. People are beginning to realize that this is an intolerable situation that can be permitted no longer. It is time to make a change in the system.

There have been attempts to develop remedial legislation; but to date there has been no significant relief achieved in any state. Committees consisting of representatives from the legal community, the medical community and the insurance community, have met and have attempted to find solutions to the malpractice problem. None has been found. Perhaps there is insufficient motivation on the parts of the attorneys and the insurance companies to change the status quo; perhaps the doctors have not been aggressive enough to change the status. I believe we doctors have a means to turn the malpractice situation around—to end the malpractice crisis—and to put malpractice back into its proper inconspicuous perspective. That means is countersuit.

Traditional and customary grounds for countersuit—malicious prosecution, abuse of process, defamation of character—have not been effective and have simply not been used successfully. A new and novel approach, a new cause of action, had to be developed. I believe this novel and innovative cause of action has been found, and it was used successfully in my recent, precedent-setting Cook County Berlin *vs.* Nathan *et al* case.

The Suit

With the help of several imaginative and interested attorneys, I decided to accuse the plaintiff and her attorney of a "tort" for suing me frivolously and without reasonable cause. "Tort" is a legal term, defined as a violation by one person of a duty or obligation he owes another that thereby harms the latter. The complaint said essentially that the plaintiff in the original malpractice suit, along with her attorney, owed me a duty so as not to involve me in litigation without reasonable cause, that they both violated that duty, and that by so doing they

(continued on page 526)

LEONARD BERLIN, M.D., is attending Radiologist, Skokie Valley Community Hospital, Skokie, Illinois, and Clinical Assistant Professor of Radiology, University of Illinois Abraham Lincoln School of Medicine, Chicago.

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Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

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Adverse Reactions: Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

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*Mielke, C.H., et al.: JAMA
235:613 (Feb. 9) 1976.

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A Time to Countersue *(continued from page 522)*

harmed me. It further stated that not only did they violate that duty, but they did so “willfully and wantonly”—i.e. recklessly, deliberately, and unreasonably.

The attorneys only were accused in a second cause of action, a second “tort”: I said they owed me a duty of conducting themselves according to acceptable standards as devised by the legal profession, and that by instituting a lawsuit against me without proper prior investigation, they fell below those standards and thus were guilty of negligence. In essence, I accused the attorneys of the same charge as that brought against physicians—failing to meet the standards of their peers.

In order to prove legal negligence, standards against which to compare the defendant attorney’s actions had to be determined. The American Bar Association has developed and published a “Code of Professional Responsibility.” All local, state and county bar associations have adopted it or a modification of it. This code, consisting of “canons,” “ethical considerations,” and “disciplinary rules,” has been enforced by the courts, and has been found to be a mandatory standard of conduct which every attorney, everywhere, must follow. The code includes many regulations, but the ones appropriate for my use were:

“A lawyer shall not handle a legal matter without preparation adequate in the circumstances” (DR 6-101 [A]2); “A lawyer is not justified in asserting a position in litigation that is frivolous” (EC 7-4);

“A lawyer has a duty and an obligation to treat with consideration all persons involved in the legal process and to avoid the infliction of needless harm” (EC 7-10);

“A lawyer shall not file a suit when he knows or it is obvious that such action would serve merely to harass or maliciously injure another” (DR 7-102[A]1).

I charged the lawyers with violating these standards, but I had to produce legal expert witnesses to testify that, in my specific case, the defendant attorneys did indeed violate those standards, and by doing so, were negligent—that they were guilty of legal malpractice. I found two such expert witnesses, and they so testified. The jury agreed with that testimony.

I attempted to use a third cause of action: barratry, which is the “wicked and willful incitement of a lawsuit between two people in the state.” However, the judge in my case asserted that it was his opinion that a charge of barratry could not be filed in civil court, that if one decided to pursue that cause, it would have to proceed through the State’s Attorney office. I am challenging this opinion; it will be left to the appeals court to decide if barratry is a viable cause of action.

Result

Although I was successful in achieving a significant judgment against the plaintiff and the attorneys who filed suit, this will have to be upheld on appeal. An appeal to the state Appellate or Supreme Court is under

way, and it could be one or two years before final adjudication is made. However, Chief Justice Burger, of the U.S. Supreme Court, is on public record as having said he feels there are too many frivolous lawsuits cluttering up our courts, and that attorneys have not been held strictly enough to their own standards and guidelines. In the current milieu of opinions such as this and recent liberal court decisions, I feel confident and optimistic that our innovative and imaginative causes of actions will be sustained. In my opinion, the higher courts will have no choice but to hold attorneys responsible for their actions, just as all the rest of society is responsible for its actions.

The time has come for doctors in every city, in every county, in every state, to stand up and fight when they feel they have been involved in a frivolous lawsuit, or when they feel they have been frivolously named as a co-defendant in a malpractice lawsuit. From the response I have had from all over the nation, from attorneys and doctors, I know there are many attorneys who will represent doctors in countersuits. I know there are many fine attorneys throughout our nation who will appear in court and testify against other attorneys who have violated the code of the legal profession. No longer must a doctor fear obtaining good legal representation; no longer must a doctor be told there is “nothing he can do” if he is frivolously sued; no longer must a doctor simply sit back and take it!

I am convinced that the legal abuses discussed must end, and they will end, in the courts. I am convinced that the final solution to the malpractice problem is in the courts—where it all began. The day has come for the courts to put an end to the legal malpractices that have caused the astronomical rise in our malpractice insurance rates, which in turn has caused an astronomical rise in health care costs. In 1932, Justice Learned Hand said, “Courts must in the end say what is required: there are precautions so imperative that even their universal disregard will not excuse their omission.” I believe the courts did just that in my case, and they will continue to do so.

Medical colleagues, I say: if in every judicial district in this nation, there arise not one, not two, but many countersuits, the courts will be inundated and attorneys, as a result, held accountable for their actions. They must, for the first time, be punished for abuses. Yes, this in itself will cause some unfortunate problems in our courts—they will be cluttered up with even more litigation, delays in trial dates will increase, and legal costs will even go higher, and already over-burdened courts and judges will be even more over-burdened.

Maybe some injured patients who do have a bona fide cause for malpractice will be discouraged for a time from bringing suit. However, in the end, the pendulum will rest where it belongs—in the center. The pendulum that has swung unfairly against the doctors in recent years will be pushed away, perhaps too far at first, I am convinced that in the end, perhaps one year, perhaps two

years, countersuits will slowly fade away and we will find ourselves back in the proper situation: if there is a legitimate cause of action, a suit will be filed, the injured patient will be compensated, and the offending doctor will be punished in the proper manner. This is where we must wind up; perhaps we must pass through an age of countersuits before we get there.

I must issue one important warning: one may countersue only if there is cause. Simply because a doctor is named in a malpractice suit, or simply because one may be found not guilty in a malpractice trial, or simply because one's insurance carrier may settle for a nominal sum, are not necessarily justifications for countersuit. Doctors who countersue, and attorneys who will represent them, must abide by the same basic standards: one cannot sue frivolously, and cannot clutter up the courts with nonsense suits, and must not harass others without reasonable cause. Neither the courts nor anybody with any conscience can deny a patient or his attorney who feel they have a reasonable case of medical malpractice, and who have performed a reasonable investigation to substantiate that case, from his day in court. The right to sue must be preserved for all—for both the injured patient and the injured doctor. Neither can be permitted to abuse the judicial process.

The time to be sued frivolously and without fighting back is passed, and will never return; the time to countersue is now!

Physician Finds Cure

(continued from page 520)

against anyone else, by the payment of a small fee. But, as always, freedom carries with it the duty to act responsibly. If that freedom is abused, a penalty will be exacted.

Editor's Note: IMJ is indebted to Dr. Berlin and Mr. Giampietro for this article. It should be noted that Mr. Giampietro received valuable assistance during the trial from Mr. Fred Grossman, Esq., the attorney for The Hartford defending against the original malpractice claim. Dr. Berlin has received many favorable responses and comments.

ISMS became interested in Dr. Berlin's claim last December. Monitoring and clearing house functions were established through the Task Force on Professional Liability Committee on Moves to Counter Litigation.

Research of various items, shepherdizing similar cases, and statistical data accumulations were accomplished for sharing with Dr. Berlin.

Recent activity, subsequent to this jury award, indicates the matter may be taken on appeal. The ISMS Board of Trustees has authorized an *amicus curiae* brief in any appeal of this, as well as provision of assistance to Dr. Berlin.

The precedent of this case presently maintains only in Cook County. However, the ramifications could be far-reaching. A decision by a higher court will provide state-wide application.

—obituaries—

CHESTER A. BLACK, M.D., Sun City, Arizona; Ohio State University College of Medicine, 1911; age 93; died July 7; member OSMA and AMA.

LESTER J. BOSSERT, M.D., Cincinnati; Cincinnati University College of Medicine, 1934; age 69; died July 7; member OSMA and AMA.

EARL HEILNER, M.D., Toledo; University of Michigan Medical School, Ann Arbor, 1926; age 77; died June 28; member OSMA and AMA.

ELBERT J. HUMEL, M.D., Cleveland; University of Louisville School of Medicine, 1928; age 75; died June 30; member OSMA and AMA.

ROBERT F. KOORS, M.D., Dayton; St. Louis University School of Medicine, 1936; age 64; died June 28; member OSMA and AMA.

ORVAL M. LAWTON, M.D., Youngstown; Case Western Reserve University, 1926; age 75; died March 20, 1975.

JACOB J. LONGACRE, M.D., Cincinnati; Harvard Medical School, Boston, 1932; age 68; died June 24; member OSMA and AMA.

WILLIAM C. MARTINDILL, M.D., Greenfield; Medical College of Ohio, Cincinnati, 1904; age 98; died June 21; member OSMA and AMA.

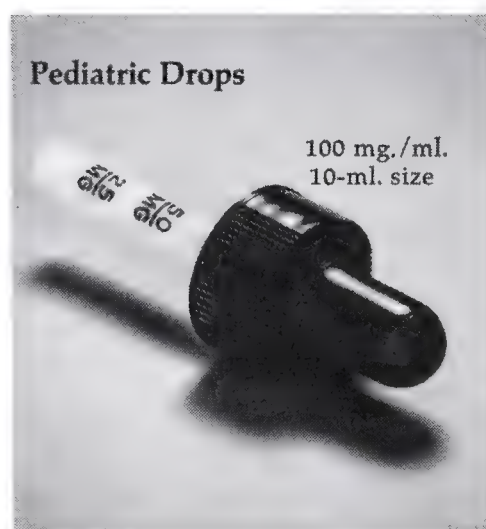
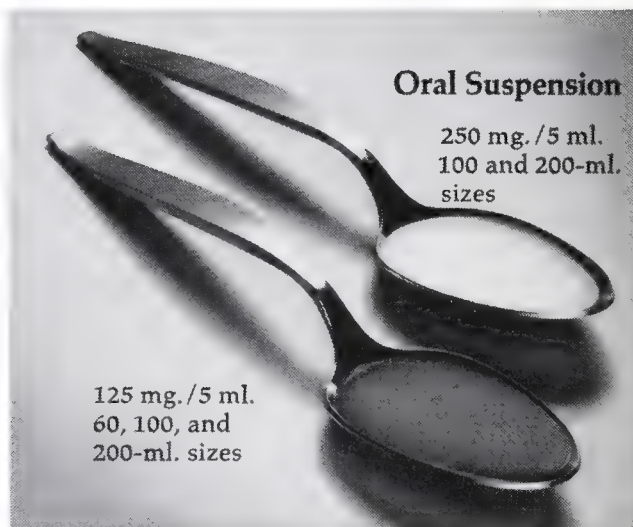
GLENN L. MILLER, M.D., Germantown; University of Cincinnati Medical School, 1942; age 62; died June 12.

ARTHUR D. NICHOL, M.D., Cleveland; Ohio State University College of Medicine, 1926; age 74; died June 22; member OSMA and AMA.

JOSEPH D. RESNICK, M.D., Akron; University of Nebraska College of Medicine, Omaha, 1924; age 82; died June 20; member OSMA and AMA.

WILLIAM W. WILTBERGER, M.D., Waverly; Ohio State University College of Medicine, 1947; age 52; died June 23; member OSMA and AMA.

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Management of Alimentary Fistulas

William R. Schiller, M.D.

This report concerns the management of 17 patients with complex alimentary fistulas. It describes a simple method of fistula drainage control using an adhesive bag-suction catheter device which allows the skin to be protected and all drainage fluid to be collected. By applying this device to a plastic skin drape placed over the entire abdomen, it is possible to efficiently collect drainage from fistulas opening into open and infected wounds. Effective methods of nutritional support, including intravenous hyperalimentation and elemental diet, have been the single most important factor in survival of these patients and in fistula closure. Eleven of the 17 patients survived the course of their illness, for a survival rate of 65 percent.

FISTULIZATION INVOLVING abdominal organs presents multiple problems in its management, including fluid and electrolyte abnormalities, progressive nutritional depletion, a wide variety of infections, and serious corrosive dermatitis. Although recent advances in controlling the fistula drainage and maintenance of nutrition have contributed to lower morbidity and mortality, approximately 15 to 30 percent of patients still succumb to this lesion.¹⁻³

We have used a previously published, simple method of fistula control which allows the skin to be protected and all drainage fluid to be collected.⁴ This technique has subsequently been perfected for use with fistulas draining into an open, infected wound and is described herein. In addition, efficient methods of nutritional support have become available and include intravenous hyperalimentation and elemental diets. These technical advances have

greatly improved the quality of nutritional support which can be provided to severely debilitated patients. Repair of metabolic defects probably remains the one most important factor in survival of these patients and in the closure of the fistula. This observation has been reported both by Chapman and coworkers,⁵ in the prehyperalimentation era, and by Roback and Nicoloff¹ and Rocchio et al,⁶ using either intravenous hyperalimentation or elemental diets.

Since the establishment of the Medical College of Ohio at Toledo, 17 patients with complex alimentary fistulas have been treated. This is a report of our experience with these patients using the newer adjuncts in therapy.

Methods and Results

Seventeen patients are included in this series comprised of six women and 11 men. The youngest was 17 and the oldest 75 years of age. All fistulas had occurred after a previous operative procedure. The types of fistulas involved are illustrated in the Table. Six were small intestinal, side fistulas in continuity; seven resulted subsequent to an anastomotic leak; three were blown-out duodenal stumps; and one was a proximal jejunostomy created at the time of a massive bowel resection. All of these patients presented with serious, complicated illnesses, 14 were referred from another institution and eight had fistulization present at the time of admission to this hospital.

Six of the 17 patients died in the course of their illness, a mortality rate of 35 percent. Four of the patients who died had anastomotic leaks; one had a side fistula of the jejunum, and the remaining patient had a blown-out duodenal stump. Sepsis was the most common cause of death with massive gastrointestinal bleeding and renal failure also contributing heavily to the mortality. Sex and

Dr. Schiller, Toledo, member of the Attending Staff, Hospital of the Medical College of Ohio; and Associate Professor of Surgery, Medical College of Ohio at Toledo.
Submitted March 30, 1976.

age did not seem to be determining factors in survival of the patients. Two of those who died suffered from massive loss of intestine secondary to mesenteric vein thrombosis, and oral contraceptives were strongly implicated as etiologic factors. All patients who died had persistent fistulization while all survivors had closed fistulas, two after definitive surgical procedures.

Many of the problems encountered are illustrated in the following clinical data.

A 55-year-old white man underwent a partial gastric resection with Billroth I reconstruction and Meckel's diverticulectomy through an upper-abdominal transverse incision with a cranial vertical extension at another hospital on September 19, 1971. Postoperatively, he developed a wound infection thought to be of clostridial origin; he was transferred to this hospital. On admission, the wound was opened widely and the following day, an enterocutaneous fistula was apparent in the base of the open wound on the left side (Fig. 1). A leak from the gastroduodenal anastomosis was confirmed on upper-gastrointestinal roentgenograms.

Following thorough cleansing of the abdomen and the open wound, an adhesive plastic drape was applied to the abdomen, completely covering the wound. A Fazio ileostomy bag was affixed to the plastic drape over the fistula tract and, through the bag and drape, a sump catheter was placed in the fistula tract, along with another sump catheter in the bag. Through a second bag, another catheter was inserted through the drape into the wound and attached to suction (Fig. 2). Using this method, the wound and surrounding skin were preserved.

Intravenous hyperalimentation was started on the eighth hospital day via a subclavian catheter into the superior vena cava; the patient received an average of 4.5 liters of the solution daily which represented about 4,500 calories and 27 grams nitrogen. After an initial diuretic phase, he began to gain approximately one-half pound daily. Fistula drainage varied from 200 to 1,500 ml daily and continued for 28 days, at which time it ceased spontaneously. When the fistula drainage was much diminished, oral intake was resumed and tolerated well. The open wound healed rapidly and did not require secondary closure (Fig. 3). The patient was discharged to his home on the 44th hospital day.

Comment.—This patient represents one of the most difficult problems seen in surgery. Upper-gastrointestinal fistulas draining into an open, infected wound result in the output of large volumes of corrosive fluid containing activated digestive and bacterial enzymes from a slowly



FIG. 1. Leaking gastroduodenal anastomosis resulting in fistula opens in left side of this open, transverse, upper-abdominal incision.

starving patient if the patient is not treated aggressively. Adaptation of the previously published drainage-collection system devised in this institution resulted in efficient collection of drainage, protection of the adjacent skin, and the healing of the wound. Vigorous nutritional support was given this patient which allowed weight gain in spite of his inability to take oral nourishment. He also

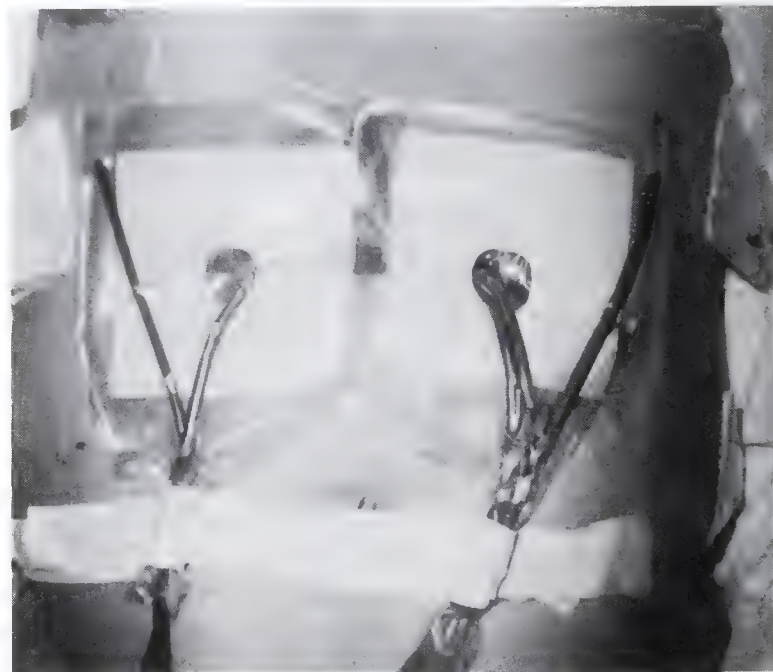


FIG. 2. Fistula-drainage collection device described is shown in place. Coverage of open wound by adhesive plastic drape provides flat surface for application of collection-bag suction-catheter device.

Site of Interocutaneous Fistulas		
Small Intestine Side Fistula		6
Jejunal fistula complicating pancreatitis	1	
Ileal fistula secondary to drainage of pelvic abscess	1	
Postoperative jejunal fistula following blunt trauma	1	
Ileal fistula following cholecystectomy	1	
Jejunal fistula secondary to shotgun injury	1	
Ileal fistula postsurgery for regional enteritis	1	
Anastomotic Leaks		7
Jejunio-ileal	2	
Esophago-gastric	1	
Gastroduodenal	1	
Jejunocolic	1	
Ileal enterotomy	1	
Gastrotomy incision	1	
Duodenal Stump Blow Out		3
End-Jejunal Fistula		1
Total		17



FIG. 3. Spontaneously closed wound as it appeared after one month.

exhibited a period of diuresis immediately following the start of hyperalimentation. This phase is commonly observed and represents the mobilization of edema fluid. Rapid weight gains have been avoided since they usually indicate fluid retention rather than gain in lean body mass. Most patients in this series required approximately 4,000 calories and 20 grams of nitrogen daily to gain weight.

A similar type of lesion was seen in another patient in this series following an enterotomy for removal of orange pulp bezoars which had caused intestinal obstruction. He also developed an enterocutaneous fistula which drained into the base of his open surgical incision. This complication was managed successfully in a manner similar to the first patient, although his wound required split-thickness skin grafting for closure. The fistula closed spontaneously in about 20 days.

A 25-year-old man was referred to our hospital after being involved in a motorcycle accident approximately one week previously. At another hospital, he had undergone splenectomy for a ruptured spleen followed by a second laparotomy 24 hours later for recurrent intra-abdominal bleeding. He was referred to us because of two episodes of gastric bleeding which had resolved spontaneously. On admission, he was not bleeding, but rather seemed to be suffering from mild ileus and an infected surgical incision. On the sixth hospital day, however, he suddenly developed massive gastric bleeding and was again operated on through the original incision. A bleeding, gastric ulcer high on the lesser curvature was found and oversewn. The left gastric artery was ligated, and a vagotomy and pyloroplasty performed which controlled the bleeding. Following this operation, he was septic with a temperature of 40.0C (104F). Blood cultures were positive for a species of *Bacteroides* and *Pseudomonas aeruginosa* (Fig. 4). He was treated with a combination of antibiotics which included gentamicin, erythromycin, and cephalothin. On the tenth postoperative day, he had recurrent gastric bleeding which was controlled by selective catheterization of his celiac artery and perfusion with a solution containing vasopressin (0.2 unit/minute).⁷ We would have preferred the left gastric artery for

perfusion, but it had been ligated at the previous operation. At approximately the same time, a jejunal fistula into the base of the open, infected, abdominal wound became evident. Intravenous hyperalimentation, which had been started on the second postoperative day, now became his only means of nutritional support; he was given approximately 3,500 calories and 20 grams of nitrogen daily by this route. Over a period of two months, the wound gradually healed, the sepsis abated, and the fistula drainage was easily collected with the double-bag and suction-catheter system although the fistula showed no sign of closing. Also of interest were the enormous daily urine outputs, ranging from five to seven liters during the septic period and subsiding to normal levels as the sepsis resolved. His weight remained constant for almost a month, but finally began to rise when his daily caloric intake was increased to 4,000 calories and the nitrogen intake to 27 grams. On the 90th hospital day, he was taken to the operating room, where the fistula and the adjacent jejunum were resected and intestinal continuity restored by an end-to-end anastomosis. He made an uneventful recovery and was discharged two weeks later. He has since returned to full employment as a factory worker.

Comment.—The recovery of this patient demonstrated that hyperalimentation can be performed in the presence of sepsis. It also demonstrated the increased need for calorie intake since weight gain did not occur until

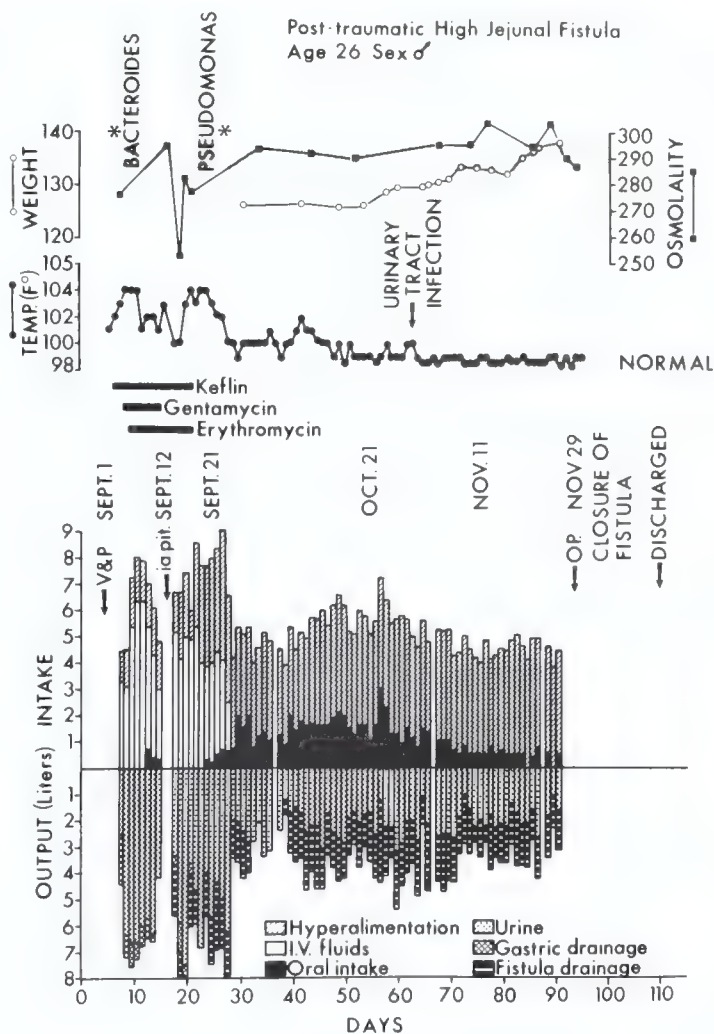
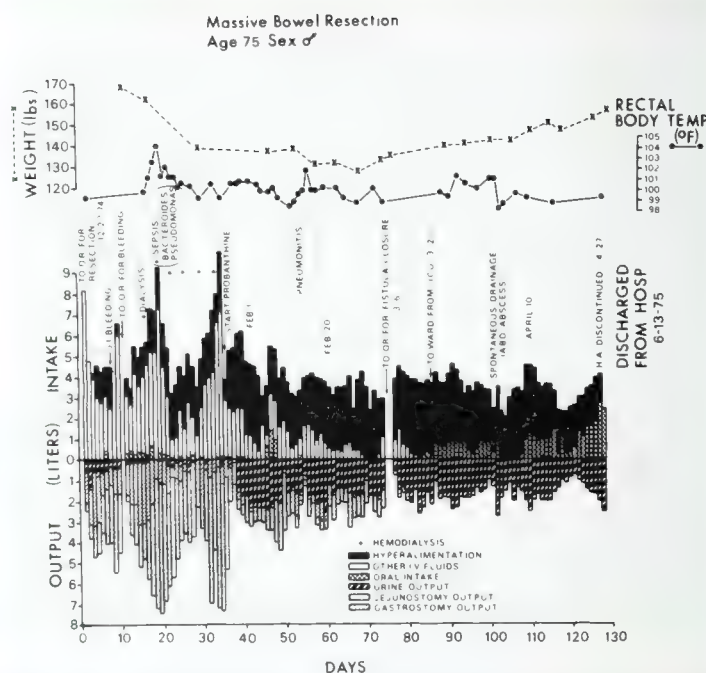


FIG. 4. Fluid balance bar graph illustrates course of patient with high-output jejunal fistula. High urine output seems to correspond to episodes of sepsis. Weight gain did not occur until high intake of nitrogen and calories was accomplished.

he received 4,500 calories and 27 grams of nitrogen. We also observed the phenomenon of a high output of dilute urine in septic patients which seemed to resolve as the fever abated. This has been observed by other workers^{8,9} although the mechanisms remain obscure. Since this urine output seems to be an obligatory response to the stress of sepsis, adequate fluid replacement as in diabetes insipidus is indicated. Resolution of the sepsis also seemed to have a beneficial effect on his metabolism, allowing for gradual, steady weight gain. This man also was saved from death by exsanguination from his stomach by the use of vasopressin infused into the celiac artery. We have found this technique to be quite useful in a variety of seriously ill patients who developed gastrointestinal bleeding.



biotics allowing the opportunistic candidiasis. Temporary discontinuance of both hyperalimentation and antibiotics usually allows resolution of candidal infections. Culture of all removed catheter tips should be performed routinely. We have not made regular use of the amphotericin catheter flush as advocated by Brennan et al.¹⁰ In spite of these efforts in management of infections, all deaths in this series were related to uncontrolled sepsis, indicating the gravity of the problem and the overwhelming nature of the lesions in most of these patients.

The skin care provided by our sump drainage system has been of excellent quality. Probably of most interest in this regard has been our experience with fistulas draining into open wounds. Once again, adequate nutritional support plays an important role in wound healing. However, credit for keeping the wounds meticulously clean must be given to our modified drainage-controlling technique. This was possible in the face of massively contaminated wounds which had been widely opened and debrided.

Our experience is in agreement with other observers who found that maintenance of positive nitrogen balance is of paramount importance in treatment of alimentary fistulas. We have used several techniques for delivering nutritional substances to these patients, including intravenous hyperalimentation, tube feedings, and elemental diets. In general, intakes in the range of 3,000 to 4,500 calories and 18 to 27 grams of nitrogen daily are required since most of the patients have increased expenditures of energy, often because of sepsis. While it is difficult to evaluate the precise effect of the present level of nutritional support, it appears that the mortality rate has been reduced. Chapman, Foran, and Dunphy⁵ reported a series in which part of the patients were optimally supported nutritionally while the remaining patients were not. In the optimally treated group, 89 percent of the fistulas closed and a mortality rate of 16 percent was reported. In the suboptimal group, only 37 percent of the fistulas were cured and 58 percent of these patients died.

Our experience also agrees with that of others, who observed that nonoperative treatment of fistulas is the preferable method, provided that suitable nutritional support is available. Under optimal circumstances, approximately half of the fistulas will close without operation. However, certain circumstances should suggest the need for operative intervention. Fistulas from any source rarely will close if obstruction is present distal to the fistula, or in the presence of malignancy or a foreign body. In the case of enterocutaneous fistulas, presence of granulomatous disease often signals the need for operation. In addition, it is generally stated that development of mucosal lining of the fistula tract precludes spontaneous closure and suggests the necessity of early operation. Persistently high output from the fistula, in spite of optimal treatment, probably should indicate the need for a surgical procedure. Complete disruption of intestinal continuity and association of abscesses with the fistulous tracts also are strongly suggestive of the need for operative intervention.

The high incidence of renal failure in patients with

gastrointestinal fistulas further complicates their management, not only because of inability to handle large-volume infusions but because the high nitrogen intakes tend to elevate the blood urea level when renal excretion of urea is inadequate. In some patients, positive nitrogen balance may not be an achievable goal. However, frequent hemodialysis may help in controlling hypervolemia and azotemia sufficiently to allow significant nutritional benefit. Also, if necessary, the amount of amino acid solution in the hyperalimentation fluid can be decreased by 50 percent to control azotemia, and increased concentrations of glucose can be given. In the near future, solutions containing only essential amino acids may become available for general use. This would allow more aggressive and efficient nutritional support in azotemic patients since they are able to utilize the urea nitrogen as a nonspecific nitrogen source and, consequently, the rise in blood urea is greatly diminished.

Assuming the necessity of a surgical procedure for closure of an alimentary fistula, some principles may be helpful in management. First, direct closure of any fistula is rarely successful. Enterocutaneous fistulas are best attacked by complete removal of the fistula and adjacent intestine followed by end-to-end anastomosis. Complete exclusion of the intestine with its fistula is a satisfactory alternative in cases where excision is not feasible. Partial by-pass of the involved segment is unsuccessful in a high percentage of cases and is not a preferred method of treatment. Finally, surgery, if indicated, should not be withheld until it becomes a last desperate measure, but rather should be applied to the problem when careful evaluation confirms its desirability.

Summary

This report concerns the management of 17 patients with complex alimentary fistulas. Fistulization involving abdominal organs presents multiple problems including fluid and electrolyte abnormalities, progressive nutritional depletion, a wide variety of infections, and serious corrosive dermatitis. We have used a simple method of fistula drainage control which allows the skin to be protected and all drainage fluid to be collected. A modification of this technique allows for drainage collection from fistulas opening into open draining wounds. In addition, efficient methods of nutritional support, including intravenous hyperalimentation and elemental diets, have greatly improved the quality of nutritional support which can be provided to severely debilitated patients. Repair of metabolic defects probably remains the one most important factor in the survival of these patients and in the closure of the fistula.

Seventeen patients are included in this series comprised of six women and 11 men. The youngest age was 17 years and the oldest 75. All fistulas had occurred after a previous operative procedure. Six were small intestinal side fistulas in continuity; seven resulted subsequent to an anastomotic leak; three were blown-out duodenal

stumps; and one was a proximal jejunostomy created at the time of a massive bowel resection.

Six of the 17 patients died in the course of their illness, a mortality rate of 35 percent. Sepsis was the most common cause of death, with massive gastrointestinal bleeding and renal failure also contributing to the mortality. All patients who died had persistent fistulization while all survivors had closed fistulas, two after definitive surgical procedures.

Generic and Trade Name of Drug

Propantheline bromide—ProBanthine (Searle Laboratories)

References

1. Roback SA, Nicoloff DM: High output enterocutaneous fistulas of the small bowel. *Amer J Surg* 123:317-322, 1972.
2. Aguirre A, Fischer JE, Welch CE: The role of surgery and hyperalimentation in therapy of gastrointestinal-cutaneous fistulae. *Ann Surg* 180:393-401, 1974.
3. Sheldon GF, Gardiner BN, Way LW, et al: Management

- of gastrointestinal fistulas. *Surg Gynecol Obstet* 133:385-398, 1971.
4. Suriyapa C, Anderson MC: A simple device to control drainage from enterocutaneous fistulas. *Surgery* 70:455-458, 1971.
5. Chapman R, Foran R, Dunphy JE: Management of intestinal fistulas. *Amer J Surg* 127:157-164, 1964.
6. Rocchio MA, Cha CM, Haas KF, et al: Use of chemically defined diets in the management of patients with high output gastrointestinal cutaneous fistulas. *Amer J Surg* 127:148-156, 1974.
7. Nusbaum M, Baum S, Blakemore WS: Clinical experience with the diagnosis and management of gastrointestinal hemorrhage by selective mesenteric catheterization. *Ann Surg* 170:506-514, 1969.
8. Powers SR Jr: Renal response to systemic trauma. *Amer J Surg* 119:603-605, 1970.
9. Rosenberg IK, Gupta SL, Lucas CE, et al: Renal insufficiency after trauma and sepsis. A prospective functional and ultrastructural analysis. *Arch Surg* 103:175-183, 1971.
10. Brennan MF, Goldman MH, O'Connell RC, et al: Prolonged parenteral alimentation: Candida growth and the prevention of candidemia by amphotericin instillation. *Ann Surg* 176:265-272, 1972.



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Spastic Dysphonia

George W. Paulson, M.D.
Janice E. Barnes, Ph.D.

Spastic dysphonia is one of several conditions that is in the borderland of neurology. It is a syndrome that can be seen in any clinic that treats extrapyramidal disorders. This is a report of ten patients with spastic dysphonia. The speech defect is often harsh, irregular, low in pitch, and tends to be slowly progressive once it appears. All patients were middle-aged, and neurologic concomitants apparently were fortuitous. Several patients did have some extrapyramidal features. An overflow of grimacing during speech was prominent in at least three of the patients. Diagnostic studies were not helpful. Under direct vision, one patient had an apparent laryngeal paralysis. A trial of L-dopa therapy in four patients produced no significant benefit, and both psychotropic drugs and stimulants were of no significant benefit. Speech therapy was of modest benefit for four patients. There were no major psychiatric problems that were causal in this group of patients. Spastic dysphonia remains a possible organic syndrome complex that should be identified by the physician, but it is one for which definitive therapy currently is lacking.

SPASTIC DYSPHONIA HAS BEEN described for over 100 years, but the cause remains enigmatic even though most articles in the literature emphasize a psychogenic basis for the disorder. Excellent reviews by Aronson et al¹ have suggested that spastic dysphonia is not purely a psychogenic disorder but is an organic disturbance of totally unknown cause. There are many extrapyramidal disorders which have been redefined in view of new therapeutic advances, and it is certain that several extrapyramidal diseases remain undescribed. For these reasons, plus the surprising frequency of spastic dysphonia in a clinic for the treatment of parkinsonism, it seems appropriate to review our experience with patients with spastic dysphonia who were seen during the past three years. From our review, we feel that the condition remains in the borderlands of neurology and psychiatry with

features for both specialties, but it often is not recognized at all by either neurologists or psychiatrists.

Spastic dysphonia is only one of several possible labels, all descriptive rather than etiologic. The descriptions have been almost as variable as the disability but in general, this disorder of speech is described as harsh, intermittent, explosive, low in pitch, squeezed, or effortful. One characteristic of the disorder is that normal voice usually can be elicited in involuntary vocalization, ie, coughing, humming, or laughing. At times, persistent whispering is a feature of the dysphonia. In addition, many patients have had an overflow of effort into facial movements, including grimacing and eye blinking, particularly. A summary of the medical findings represented by patient reviews and reactions to the therapy used is cited herein.

Patient 1. — A 59-year-old woman had exhibited several years of speech difficulty with intermittent aphonia; her voice had a harsh and metallic sound. There was mild difficulty with palatal elevation, and she seemed to have difficulty with rapid-tongue movements. Otherwise, findings on her neurologic examination were entirely normal; otolaryngologists found no abnormality. She was placed on a regimen of benztropine mesylate and local anesthetics, as well as Valium.[®] There was no significant improvement with this therapy or with treatment with L-dopa.

Patient 2. — A 60-year-old woman had been known to "talk deeper" for five or six years. The speech handicap had interfered with communication, but she had never had an aphasia. While speaking, she noted a tense feeling in her chest but, otherwise, a complete review of systems was unremarkable. When she moved her eyes from side to side, there was an overflow reflex movement of her mandible to the contralateral side. There also was quivering of her mentalis muscle and mild facial grimacing associated with the dysarthric speech. Almost every syllable came out in a forced, harsh, and guttural sound but, otherwise, the result of neurologic examination was normal. Stridor and the harsh voice prompted a careful ear, nose, and throat (ENT) assessment, which revealed bilateral vocal cord paresis of undetermined etiology. A trial of various tranquilizing medications, as well as trihexyphenidyl hydrochloride, was of no benefit. Speech therapy brought temporary benefit. Surgery of the vocal cords with partial approximation of them did afford a modest improvement in her speech, but the result was only temporary.

Patient 3. — A 48-year-old woman had a clinical diagnosis of mild encephalitis, not confirmed by spinal fluid examination but based on a confusional state which lasted for ten days. One year later, she developed difficulty with her speech. At examination, she had a tense expression and an unblinking, extrapyramidal-type stare. There was a minimal decrease in swing of her

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left arm and leg when she walked, and hyperreflexia on that side. Her speech was guttural; she had difficulty in protruding her tongue, with excess salivation. The speech difficulty had progressed slowly, but it did not change during the year the patient was under observation. Otherwise, results of neurologic and ENT examinations were normal. Administration of diazepam was associated with reduction in the speech difficulty; trihexyphenidyl hydrochloride therapy was without significant benefit.

Patient 4. — A 73-year-old woman developed stridor slowly over a three-month period of time, and had associated shortness of breath during exercise. Findings on neurologic examination were normal except for a slight decrease in vibration sense in her legs, which was considered to be normal for her age. ENT evaluation revealed bilateral vocal cord paresis with no other abnormality.

Patient 5. — A 61-year-old woman was seen by a speech therapist who diagnosed her problem as spastic dysphonia. She had been evaluated previously by an otolaryngologist who found the larynx and vocal cords were normal. The voice problem began two years earlier while she was under emotional strain, and increased following the death of her husband. Her voice was characterized by vocalization during inhalation, and the vocal attempts tended to be "squeezed out." Diaphragmatic breathing was suggested, and a therapy session was recommended. She attended three therapy sessions, but, as happens with many patients with spastic dysphonia, she did not elect to continue therapy.

Patient 6. — A 37-year-old man had experienced voice problems for approximately a year and a half; he attributed the voice difficulty to a change to a more stressful job. His voice problem was worse when speaking to persons of high authority and in other stressful situations. At these times, speech was characterized by a high-pitched, strained sound which occasionally softened into a normal quality. At times, he could produce a normal, clear quality in all ranges of pitch. The ENT evaluation was normal except for speech. It was felt that this was most likely a psychogenic disorder but, as is typical of patients with this type of voice disorder, he cancelled his psychiatric appointment and did not return for speech therapy.

Patient 7. — A 57-year-old woman exhibited normal laughing, sounds of clearing the throat, humming, normal voice combined with breathing, and normal whispered speech. However, during normal speech she had a guttural, spastic voice which was thought to be largely a functional problem. She related it to a fall from a ladder. This patient was started on speech therapy but failed to continue the therapy.

Patient 8. — A 38-year-old woman had been examined by numerous physicians, including internists, psychiatrists, and neurologists, and had no defects except speech. She had extreme subglottic pressure with obvious tension while speaking. Because of this, she avoided speaking situations and would answer the telephone rarely. She felt a sense of strain and fatigue in her throat when speaking, but was able to hum with comfort. A regimen of L-dopa was of no benefit to her. She was evaluated jointly with another patient in a group situation for speech therapy; both patients alluded to major psychological problems and, therefore, were referred to a psychiatrist. She did not attend the psychiatrist, but the dysphonia cleared completely after voluntary silence for two weeks.

Patient 9. — For 18 months, a 67-year-old lawyer experienced a feeling as if something were stuck in his throat. His speech had become progressively harsher, especially with fatigue. He could produce a perfectly clear, low-pitched voice, but the spastic quality appeared in conversation. His handwriting also had become cramped and unsteady. At examination, there was minimal tremor with hands extended, and slightly increased tone in his neck and shoulders. Results of the remainder of the examination were normal. Neither levodopa nor trihexyphenidyl hydrochloride therapy alleviated the speech difficulty.

Patient 10. — A 32-year-old woman was referred by otolaryngologists who had found that her vocal cords were completely normal. While lecturing, she had discovered that her throat felt "raspy" after a bronchial infection, and there appeared to be muscle spasm and harshness of tone. The speech difficulty increased in severity over a period of months, and was greatly increased after a bout of laryngitis. Muscle relaxants, such as diazepam, had

not helped although complete voice rest for two weeks did produce a significant improvement. With various speech exercises, she improved dramatically. The speech therapist felt that the patient complicated the problem in attempting to compensate for the raspy voice by pitching her voice lower. When instructed to move toward the upper range, her speech soon cleared.

An effort was made to identify psychiatric problems in these patients, and six out of ten patients could be located 12 to 18 months after having been seen. Neither the initial assessment nor follow-up revealed a specific or characteristic psychologic pattern although formal psychologic testing was not done. All the patients were convinced that organic factors were heavily contributory, or causal, in the speech disturbance. Most had apparently stable, though possibly superficial and formalized relationships with their spouses or employers. As with several other "borderland" disorders that overlap neurology and psychiatry, such as migraine or atypical facial pain, the patients appear to be more obsessive than the population at large, and the spouses are more accepting and tolerant than the average seen in a physician's office.

Discussion

Many etiologic theories have been suggested for spastic dysphonia. Critchley, in 1939,² and others, including Robe et al, in 1960,³ noted minimal or no neurologic deficit in many cases but did find mild pyramidal tract signs, hyperreflexia, and tremor in a few cases. On the basis of such observation, Aronson et al¹ have suggested that the disease represents an organic process, although one that is ill-defined and uncertain. In Aronson's series, special psychologic studies, including Rorschach tests, did not suggest a definitive pattern of psychologic disturbance. Certainly his patients, as well as those observed here, had no specific or predictable psychiatric problem. Several of Aronson's patients had been depressed due to the speech difficulty which often tended to be slowly progressive, but in no patient was depression a prominent feature. Whether the psychologic problems could be purely causal is problematic; difficulty with speech must be extremely anxiety provoking and can easily lead to a severe reactive depression.

Our group of patients with spastic speech is similar to those in other series with involvement of many etiologic factors. Bilateral vocal cord paresis of an idiopathic type was present in two cases; cases of spontaneous paralysis do occur in elderly populations. One patient had a probable postencephalitic spasticity which included hyperreflexia of the limbs and jaw jerk, as well as difficulty with rapid tongue movements. In this case, neuronal scarring or vascular changes and resultant spasticity could have played a role. Several cases had the appearance of a mild extrapyramidal disorder associated with their speech difficulty.

It is difficult for a neurologist to detect specific qualities in speech, and quantification is subjective. The neurologist could observe that these cases usually could produce normal voice in certain situations but, with conversation, would lapse into spastic and harsh dysphonia.

Several patients recovered with speech or psychiatric therapy; none was benefited by treatment with drugs. In at least one case, a period of total silence for two weeks was associated with a cure, but the dramatic quality of the silence—rather than the rest itself—may have been crucial.

It seems probable that more than one etiology can lead to spastic dysphonia. In addition to psychiatric disorders—conversion reactions, neurologic disorders such as Parkinson's disease, and otolaryngologic problems such as idiopathic paresis of the vocal cords—there are probably other "borderland" disorders that can lead to speech problems. For example, the facial grimaces of Meige's syndrome⁴ and the mouthing movements of tardive dyskinesia⁵ can both produce abnormalities of speech.

Therapy is obviously difficult. Treatment with levodopa was of no benefit to three of these patients. Trihexyphenidyl hydrochloride therapy also failed in at least three patients. Therapy with diazepam and similar muscle relaxants was of modest benefit for several patients, though major tranquilizers had no significant effect. Speech therapy has been of benefit to several, perhaps by

increasing suprasegmental factors in some cases, relieving anxiety in some, encouraging voluntary inhibition of the spasticity, or even by specific technical advice. The most likely patient error is to pitch the voice low and, thereby, aggravate rather than ameliorate the difficulty. Currently, the etiology and, consequently, the therapy must be considered multifaceted in this heterogeneous group of disorders in the borderlands of neurology.

References

1. Aronson AE, Brown JR, Litin EM, et al: Spastic dysphonia. I. Voice, neurologic, and psychiatric aspects. II. Comparison with essential (voice) tremor and other neurologic and psychogenic dysphonias. *J Speech Hear Disord* 33: 203-231, 1968.
2. Critchley M: Spastic dysphonia ("inspiratory speech"). *Brain* 62:96-103, 1939.
3. Robe E, Brumlik J, Moore P: A study of spastic dysphonia: neurologic and electroencephalographic abnormalities. *Laryngoscope* 70:219-245, 1960.
4. Paulson GW: Meige's syndrome. Dyskinesia of the eyelids and facial muscles. *Geriatrics* 27:69-73, 1972.
5. Crane GE, Naranjo ER: Motor disorders induced by neuroleptics. *Arch Gen Psychiatry* 24:179-184, 1971.

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Incidence of Hypothyroidism Following Small Doses of ^{131}I in the Treatment of Graves' Disease

F. Perry McCullagh, M.D.
Gwynn L. Jelden, M.D.
Antonio Rodriguez-Antunez, M.D.

In a group of 147 patients treated with ^{131}I in doses of 3.0 millicuries or less for Graves' disease, the incidence of hypothyroidism was calculated 10 to 17 years after treatment. This paper emphasizes the frequency of hypothyroidism after treatment with ^{131}I in small doses, if sufficient time lapse is considered.

THE INCIDENCE OF hypothyroidism was calculated 10 to 17 years after treatment with ^{131}I in doses of 3.0 millicuries or less in a group of 147 patients. Of 100 patients in the study, 78 were women and 22 were men. The average age of the women was 42.3 years; the youngest was 19 years old and the oldest was 73. Average age of the men was 42.6 years, ranging in ages from 20 to 66 years.

Methods and Procedures

The diagnosis of Graves' disease was made if typical signs and symptoms were present, including a diffuse (hyperplastic) goiter which might vary in size from slightly perceptible enlargement to one estimated to weigh 150 grams. Readily palpable pulses over the thyroid arteries, readily audible bruit, or typical exophthalmos were considered good confirmatory evidence. Supporting laboratory findings included a basal metabolic rate (BMR) of over +15 percent, an elevated level of protein-bound iodine (PBI) or serum T_4 , suppressed level

of serum cholesterol, an elevated thyroidal uptake of ^{131}I , and definite clinical improvement after ^{131}I therapy.

The diagnosis of myxedema or hypothyroidism was made clinically and by appropriate confirmatory laboratory tests. A PBI level less than $3.5\mu\text{c}/100\text{ ml}$ was given considerable attention. If symptoms and signs indicated the presence of myxedema but the PBI was within normal range, the PBI test usually was discounted. The PBI determination utilized the method of Leonards and Davoren.¹ A plasma cholesterol concentration of 300 mg/100 ml or above favored the diagnosis of hypothyroidism. The BMR was measured by the oxygen consumption method with a Sandborn "metabolator." An average of two basal metabolic rates, one immediately after the other, was used.

Among the 147 patients, 15 were listed as suspect. In addition to the tabulated data for nine patients in Table 1, some data for others are noted in Tables 2 and 3. The data leading chiefly to the suspicion of hypothyroidism are underlined.

There was some suspicion on clinical grounds in all cases. Results of some of the tests were abnormal in all patients. The cholesterol value was abnormally high in only one case. In our judgment, the evidence was not sufficient to warrant a definite diagnosis of hypothyroidism, especially since the BMR was abnormally low according to one test (two runs) in only one incidence. In some cases, it is not unlikely the BMR has been in error, but there was no opportunity to repeat it. The possibility of an excess of triiodothyronine seems unlikely since the ^{131}I thyroidal uptake was low.

All patients were considered hypothyroid except two, one of which has marked euthyroid and one suspect. The order is arranged according to calculated ^{131}I retained per gram.

There seems to be no correlation between the calculated amount of ^{131}I retained in the thyroid and the eventual prevalence of hypothyroidism. Only one patient shown in Table 3 was estimated to have retained more

Dr. McCullagh, Cleveland, former Head of Department of Endocrinology and Metabolism, The Cleveland Clinic, is Emeritus Consultant, The Cleveland Clinic.

Dr. Jelden, Cleveland, Department of Radiation Therapy and Nuclear Medicine, Cleveland Clinic Center.

Dr. Rodriguez-Antunez, Cleveland, Director, Department of Radiation and Nuclear Medicine, Cleveland Clinic Center.

Submitted December 26, 1975.

TABLE 1. Patients Classed as Myxedema Suspects Treated with ¹³¹I Ten to 17 Years Before Final Evaluation or Examination

Patient	BMR	PBI	Plasma Cholesterol	¹³¹ I Uptake (24 hr)	Remarks
1.	-2	4.8		<u>4%</u>	Symptoms. Off thyroid therapy 2 months
2.	-10		280	<u>3%</u>	Symptoms. Off thyroid therapy 1 month
3.	-17	3.9	<u>315</u>		Mild symptoms
4.	+3	<u>3.2</u>	220	<u>5%</u>	
5.		<u>2.8</u>			
6.	+5	<u>3.0</u>	220	<u>2%</u>	Off thyroid therapy 3 weeks
7.	-2	<u>2.7</u>	155	<u>3%</u>	
8.	-4	<u>2.6</u>	260	<u>5%</u>	
9.		<u>1.9</u>	240		

than 114 µc/gm of ¹³¹I, which is the maximum retention estimated for the patients in Table 1.

Comments

It has been established that each year after ¹³¹I treatment for Graves' disease, 2 to 5 percent of patients become hypothyroid.² It also has been demonstrated that reduced dosage of ¹³¹I will lower the incidence of hypothyroidism up to five to ten years after treatment.^{1,3-5} Our study demonstrates the incidence of hypothyroidism up to 17 years or more after treatment with ¹³¹I in doses of 3.0 mc or less.

Twenty-four patients given 3.0 mc or less of ¹³¹I are listed in Table 2. Their data may be compared with the data in Table 3, showing results in 20 patients given large doses of ¹³¹I.

Patients reported here were given low doses in an attempt to avoid hypothyroidism as often as possible. Such low doses were used in patients who had mild hyperthyroidism and small goiters.

The data show that approximately 90 percent of all patients treated with ¹³¹I in doses of 3.0 mc or less developed hypothyroidism within 17 years after treatment.

TABLE 2. Clinical Data of 24 Patients Treated with Doses of ¹³¹I in Doses of 3.0 mc or Less and Followed for 17 Years or More

Patient	Est. Wgt. of Goiter (gm)	Total Dose of ¹³¹ I (mc)	Est. ¹³¹ I Retained Per gm Thyroid (µc/gm)	Time Lapse from Therapy to Diagnosis Years-Months	Supporting Evidence and Tests While Not on Therapy		
					BMR	PBI	Cholesterol
1	28	3.0	40	17	Myxedema—complete response to treatment. ¹³¹ I uptake 7%/24 hr.		
2 Hyperthyroid	35	2.0	43	1	Hyperthyroid—Retreated with ¹³¹ I		
3	40	2.0	54	16	-26		360
4	20	2.0	60	5	-23		
5 Euthyroid	30	3.0	60	16	-18	No symptoms 4.5	263
6	35	2.5	62	2	-28		
7	25	2.0	64	3	-10	3.4	452
8	30	3.0	64	13	-25		
9	25	2.0	64	5	-5	1.7	345
10	35	3.0	68	3	-19		348
11	35	3.0	68	16	-13	1.3	Excellent response to therapy
12	35	3.0	68	3	-28		
13	35	3.0	70	6	-25		
14	30	2.5	72	1	-21	3.0	
15 Euthyroid	30	2.5	73	12	15	5.0	Uptake 17% 5½ hrs.
16	40	3.0	75	3	Myxedema—Complete response to therapy		
17	30	3.0	77	11	-26	3.1	254
18 Suspect	34	3.0	77	10			
19	40	3.0	80	4	-25		275
					Myxedema—Complete response to therapy		
20	30	3.0	85	10	-18	3.3	340
21	35	3.0	90	4	-27	0.7	310
22	30	3.0	95	11	-16	3.4	452
23	25	3.0	114	10	-17	2.8	310
24	35	3.0		3	-28		

BMR refers to percentage of normal.
PBI given as µ/100 ml.
Serum cholesterol figures in mg/100 ml.
Treatment and response to treatment mentioned refer to thyroxine or dessicated thyroid given orally.

TABLE 3. Thyroid Status of Patients After ¹³¹I Doses of 3.0 mc or Higher in Treatment of Graves Disease in 1948 Followed Until Recognition of Hypothyroidism or for 17 Years.

Patient	Total Dose ¹³¹ I (mc)	Calculated ¹³¹ I Retained μ c/gm of Thyroid	Time to Recognition of Hypothyroidism		Supporting or Confirmatory Evidence		
			Years	Months	BMR%	PBI	Cholesterol
1	6.0	40	17		-28		306
2	4.0	48	2		-22	1.2	
3	4.0	63		6	-26		
4	3.0	63		3	-26		346
5	6.0	73	3		-28		
6	4.0	75		3	-21		
7	3.0	75	1		-20		500
8	8.0	75	17			1.7	400
9	3.0	75	3		Typical clinical myxedema Complete response to T ₄ therapy <u>+2+3</u>		
10 Euthyroid	3.0	80	4				<u>275</u>
11	6.0	83	17			2.3	
12	7.0	90	1		-25		320
13	10.0	95	17		<u>+2</u>	<u>4.9</u>	<u>230</u>
14	4.0	100		5	-19		340
15	10.0	106	1		-16	2.7	
16	13.0	128	17			3.4	
17 Suspected	12.0		17		<u>+6</u>	<u>2.2.3.2</u>	180
18	4.0			6	-28,-28		
19	8.0			6	Typical clinical myxedema Complete response to T ₄ therapy -26		
20	20.0 (4 doses)		2				
Average	6.9	7.9					

It is not evident, however, that a plateau of incidence had been reached at that time.

The patients in Table 2 are listed in order of magnitude of the number of microcuries of ¹³¹I retained per gram of thyroid tissue, based on uptake and estimated gland weight. It is recognized that there is considerable inaccuracy in such figures. As Beierwaltes and Wagner⁶ have pointed out, estimates of weights of glands less than 50 gram may be too large by as much as 50 percent. By this criterion, the median dose of ¹³¹I 68 microcuries retained per gram of gland actually may be substantially less than the figures stated. Graves' disease usually is controlled by a single dose of from 5 to 14 mc. For example, 63 percent of 3,285 patients with Graves' disease treated with ¹³¹I at the Cleveland Clinic between 1947 and 1966 were controlled by a single such treatment. Less than 1 percent of the patients required four or more treatments, and only two of these needed doses in excess of a total of 100 mc.⁷ It was evident from this study, as it has been from others, that large doses of ¹³¹I cause hypothyroidism more rapidly than do small ones.

None of the patients reported in this paper was re-treated with ¹³¹I, except one (case 2 in Table 2), who had recurrent hyperthyroidism one year after ¹³¹I therapy in a dose of 2.0 mc. None was given thiourea or any other antithyroid drug following ¹³¹I therapy.

We agree with Dunn and Chapman,² and Crile and Skillern⁷ that ¹³¹I therapy is effective. It is considered by our staff as the safest treatment for almost all patients who have hyperthyroidism with diffuse goiter of Graves' disease. Although, like most others, we previously did not use this treatment in young people; we now advocate it.⁸

We concur with Safa and Skillern⁹ that all patients with Graves' disease be treated with relatively high doses of ¹³¹I, usually between 10 and 15 mc, since hypothyroidism may be considered inevitable regardless of the size of the dose. Doses in use at present may vary from 5.0 to 15.0 mc, average 10.5 mc.

References

1. Leonards JR, Davoren PR: A semi-automatic determination of protein-bound iodine. *Ann NY Acad Sci* 102:83-86, 1962.
2. Dunn JT, Chapman EM: Rising incidence of hypothyroidism after radioactive-iodine therapy in thyrotoxicosis. *N Engl J Med* 271:1037-1042, 1964.
3. Smith RM, Wilson GM: Clinical trial of different doses of ¹³¹I in treatment of thyrotoxicosis. *Br Med J* 1:129-132, 1967.
4. Hagan GA, Oullette RP, Chapman EM: Comparison of high and low dosage levels of ¹³¹I in the treatment of thyrotoxicosis. *N Engl J Med* 277:559-562, 1967.
5. Segal RL, Silver S, Yohalem SB, et al: Myxedema following radioactive iodine therapy of hyperthyroidism. *Amer J Med* 31:354-364, 1961.
6. Beierwaltes WH, Wagner NH Jr: Therapy of thyroid diseases with radioiodine, in *Principles of Nuclear Medicine*, H N Wagner Jr (ed), Philadelphia, W B Saunders, 1968, p 348.
7. Crile G Jr, Skillern PG: Advantages of radioiodine over thyroidectomy in the treatment of Graves' disease. *Cleve Clin Q* 35:73-77, 1968.
8. Safa AM, Schumacher OP, Rodriguez-Antunex A: Long term follow-up results in children and adolescents treated with radioactive iodine (¹³¹I) for hyperthyroidism. *N Engl J Med* 292:167-171, 1975.
9. Safa AM, Skillern PG: Treatment of hyperthyroidism with a large initial dose of sodium iodide ¹³¹I. *Arch Intern Med* 135:673-675, 1975.



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1. Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976. See reverse side for prescribing information.

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Proceedings of the House of Delegates

August 1, 1976 Special Session

The first Special Session of the House of Delegates in the history of the Association was called to order by President George N. Bates, M.D.

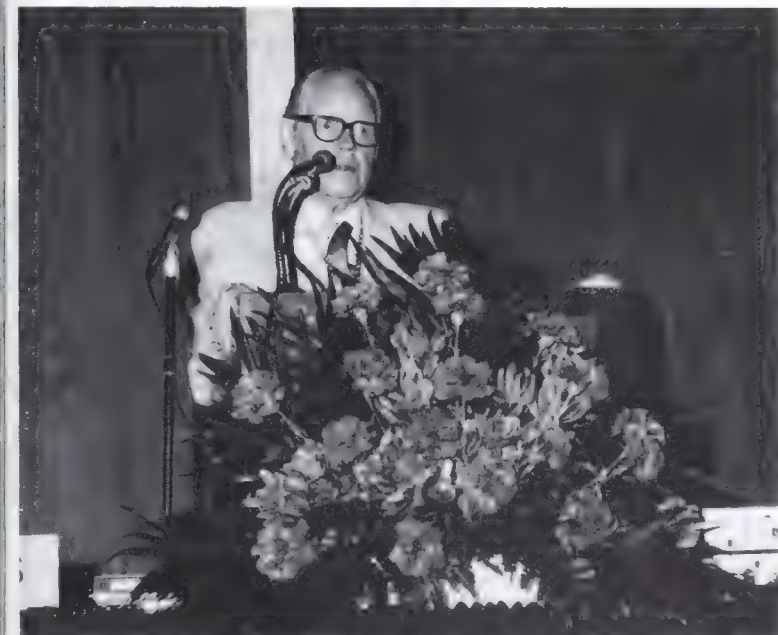
Dr. Bates introduced James L. Golden, Ph.D., Director of Communications, The Ohio State University, the parliamentarian obtained in accordance with Resolution No. 1-76; and Thomas C. Coady, Esq., Legal Counsel, serving in the absence of James E. Pohlman, Esq.

Dr. Bates announced proposed legislation for relief for providers under the A/New Jersey Influenza Immunization Program and requested the support of such legislation.

A report on the negotiations by OSMA with Medical Mutual of Cleveland, with regard to the divestiture and sale of Ohio Medical Indemnity, Inc., was delivered by Dr. Bates.

REPORT ON DELEGATES PRESENT

Dr. Andrew J. Weiss, Cincinnati, Chairman of the Credentials Committee, reported that out of 178 delegates eligible to vote, 145 were present and seated.



George N. Bates, M.D., OSMA President

ADDRESS BY THE PRESIDENT

President Bates then delivered the following address:

Members of the House of Delegates, this is a momentous event for the Ohio State Medical Association. According to all available records, this is the first time the House of Delegates has been called into special meeting.

It is a most serious event. *The decisions you make here today will touch the life of every resident of Ohio.*

On the occasion of my installation as your President at this year's Annual Meeting in Cincinnati, I called on the delegates to leave the meeting not with a sense of ending . . . *but a sense of beginning.*

It is in that same spirit that I have called . . . with the whole-hearted support of The Council and our Task Force on Professional Liability . . . this special meeting.

At the Cincinnati meeting, this House resolved, "that the Ohio State Medical Association Council continue to research the feasibility of forming a health care provider-owned insurance company and report its recommendations to the House of Delegates as soon as possible." We meet today to carry out that directive.

Members of the House, in order that there be absolutely no doubt as to why we are here, I want to state clearly, . . . frankly, . . . and directly . . . that The Council strongly urges that OSMA form as quickly as feasible a professional liability insurance company.

Before I discuss the steps that must be taken and the course of action recommended, I believe a brief review is indicated.

The Ohio State Medical Association's Council, Task Force, other committees, officers, legal counsel and staff have literally spent thousands of hours over the past five years . . . seeking lasting, viable solutions to the professional liability insurance crisis.

We have . . . with the patience of Job . . . explored and examined every possible avenue . . . regardless of how remote . . . with the legal profession . . . the insurance industry . . . the Ohio General Assembly.

In addition, this House of Delegates has engaged in countless hours of examination of the problem, in debate and in decision-making.

We began to see the light at the end of this long, dark tunnel last year when we achieved, in the Ohio General Assembly, enactment of House Bill 682. This gave us breathing room. We were able to assure physicians that coverage would be available. We were able to "buy time" to develop long-range solutions. Regardless of what some are saying, H.B. 682 is *working.*

Your OSMA has examined in great detail the professional liability insurance companies developed or planned by other state medical associations. We have gone into those states and had many productive, informative conferences.

We have had in-depth discussions with what we believe to be some of the finest insurance consultants in the nation.

We have given serious consideration to the growing inclination of commercial companies to withdraw entirely from the professional liability insurance market.

We have engaged some of the best actuaries in the nation.

We have actively and successfully— for the time being— opposed the filings of 145 percent premium rate increases made June 1 with the State Superintendent of Insurance. As of today, ISO has filed new rates with a 30 percent increase, a significant reduction in their filing, but an increase, nevertheless.

At the same time, we have pressed forward in keeping with the directives of this House of Delegates.

Before going into the details of our recommendations, I want to thank and to commend those concerned and involved OSMA members who have voluntarily contributed \$100 or more, to our Professional Liability Task Force research fund. As of July 30, 1,928 members had contributed \$193,692.64 to this fund. We believe we will be able to devote a significant

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Proceedings of House (continued)

amount of this money toward the organization of our insurance company. Ohio medicine owes a vote of thanks to those physicians.

This brings us to August 1, 1976. Let's get down to brass tacks.

I will outline for you as clearly as I am able the steps to be taken . . . and the approximate timetable in forming a company and offering professional liability policies to our members.

First, it is recommended that a *stock company* be formed as quickly as possible.

Stockholders and policyholders will be limited to members of the Ohio State Medical Association.

Although Ohio law requires an insurance company to be capitalized at $2\frac{1}{2}$ million dollars, it is our intention to set a goal of 12 million dollars to capitalize the company. This will assure us of actuarial and fiscal soundness.

Subject to prior approval of the offering circular by the Ohio Department of Insurance, we will immediately offer shares to all members of OSMA.

It is our hope to be able to begin stock sales by September 1. This means that on or before that date, we would *mail an offering circular to the membership*.

It is our hope that we would achieve the capitalization quickly enough to enable us to receive a certificate of authority to begin offering professional liability policies by *November 1* . . . three months from today.

The stock and the policies will be offered by direct mail. There will be no agents and, therefore, no commissions to be paid. We estimate a 15 percent savings.

There will be two classes of stock sold. Common stock will be sold to the OSMA, which will then have control of the company. Preferred stock will be sold to OSMA members. Each policyholder will be required to be a stockholder.

Only OSMA members will be eligible to apply for professional liability insurance.

The company will offer basic coverages of \$100,000/\$300,000 with possible expansion of limits in the future.

It is our goal to have 3000 policyholders within sixty days after receiving the certificate of authority from the Department of Insurance.

We recommend that excess coverage be purchased by the members from the Ohio Joint Underwriting Authority or the private market until such time as our company can sell such policies.

We recommend the American Medical Assurance Company . . . organized by the American Medical Association . . . for reinsurance.



John E. Albers, M.D.

OSMA, through the Council, will appoint the board of directors of the company on an annual basis. This is necessary to assure the membership that it originates as and continues as a physician-directed corporation. It is recommended that the first board will consist of the following persons: George N. Bates, M.D., Toledo, chairman; William M. Wells, M.D., Newark, vice-chairman; Maurice F. Lieber, M.D., Canton; Robert G. Thomas, M.D., Elyria; Stewart B. Dunsker, M.D., Cincinnati; John J. Gaughan, M.D., Cleveland; James L. Henry, M.D., Grove City; A. Burton Payne, M.D., Ironton; Hart F. Page, Columbus; James E. Pohlman, Esq., Columbus; and the president of the new company, who has yet to be selected.

Upon approval of our recommendations by this House of Delegates, the Task Force on Professional Liability will immediately begin a search to engage an expert insurance staff to administer the affairs of the company.

We have worked as carefully and as diligently as possible . . . ever mindful of the urgency of the professional liability crisis . . . in preparing the recommendations you are to consider today.

I don't believe there is a person in this room who does not understand and appreciate the need for immediate action.

If the House of Delegates adopts and approves the action of the Council regarding the formation of the insurance company, it must be recognized that many decisions have yet to be made: for example, rate structures, specialty classifications, management, investment counsel, accountants, actuaries, etc. The Council believes that, while these matters are important to all members of the Association and certainly to potential policyholders of the company, they are of such a serious nature and can consume so much time in the decision-making process that these matters should be the ultimate responsibility of the Board of Directors of the new company. Any suggestions regarding such matters from any delegate are invited to be submitted to the Council or the Board of Directors.

Both as your President . . . and as a deeply concerned physician . . . I personally and as strongly as possible ask this House of Delegates to approve these recommendations.

The time for decision is now.

I urge you to expedite this approval so that we may proceed immediately to do those things that must be done.

I now call on the President-Elect of the Ohio State Medical Association, Dr. William Wells, to present the report of The Council.

RECOMMENDATIONS OF THE COUNCIL

Dr. Wells was introduced and presented the following recommendations of the Council of the Ohio State Medical Association:



Raymond J. McMahon, Jr., M.D.

Mr. President and Members of the House of Delegates, the OSMA Council, as Dr. Bates has indicated, has, with the Task Force, been working diligently on researching the feasibility of forming a physician-owned professional liability insurance company. This research has proved two things which need to be clear to the members of this House.

First, the Council feels the OSMA must take some action to provide adequate malpractice insurance at a fair cost to qualified OSMA members needing this protection. The commercial insurance carriers are leaving the State of Ohio, not as quickly now, perhaps, as last year, but still leaving. The only other source of insurance for our members is the JUA, which is operated by and for State government. That means that unless we take action now, many OSMA members will have no choice but to purchase insurance through the government. Secondly, the Council feels that the climate for malpractice is changing in our favor. Public opinion seems to be changing in Ohio away from the eagerness to sue physicians. Court reforms are slowly but surely starting to take effect.

Countersuit activity by physicians wrongly sued may result in only the meritorious claims being filed and taken to the courts. For these, and other reasons, then, it appears that now is a propitious time to start an insurance company, owned by the OSMA with the full and active participation of OSMA members.

The Council has also researched, in depth, the structure such a proposed company should take. The Delegates' Handbook reviewed the three ways such a company could be formed: (1) Reciprocal, (2) Mutual, and (3) Stock. Of these three, the stock company appears clearly to offer the best mechanism to assure a successful venture. Reciprocals were ruled out because of the uncertainty of assessment should the project fail. Mutuals, while more advantageous than reciprocals, were also rejected because of the remoteness of the possibility of any participant ever getting back any funds given for capitalization. The stock vehicle allows the physician policyholder to purchase shares of stock instead of simply making a donation to achieve capitalization. This stock, which could be part of the physician's regular investment portfolio, maybe even part of his Keogh Plan, could eventually return the investment if the company is successful.

The Council, therefore, recommends to this House that an insurance company be formed to be owned by OSMA and the physicians of Ohio to sell medical professional liability insurance; that the original Board of Directors be Drs. Bates, (Chairman of the Board), Wells, (Vice Chairman), Lieber, Thomas, Dunsker, Gaughan, Henry, and Payne, together with the OSMA Executive Director, the OSMA Legal Counsel, and the president of the company; that this Board be empowered to form the company immediately and that it appoint a well-qualified chief executive officer; that the company be a stock company; and finally, that the company be called the Physicians Insurance Company of Ohio, and, Mr. President I move approval of these Council recommendations.



Left to right: A. Burton Payne, M.D.; Robert G. Thomas, M.D.; William M. Wells, M.D.; and Thomas C. Coady, Esq.



Jack Schreiber, M.D., and H. William Porterfield, M.D.

The motion by Dr. Wells was seconded by Dr. Rocco Antennucci, of the Twelfth Councilor District.

Dr. Jack Schreiber, Mahoning County, moved to postpone indefinitely action on the recommendations. After debate on the issue, the motion was withdrawn with no objections from the House.

By official action, the House moved to go into a meeting of the committee of the whole.

After lengthy discussion, a motion was adopted to dissolve the committee of the whole and to reconvene in regular session.

In regular session, Dr. Schreiber made the following motion: "That the stock company be formed for organizational purposes and that complete details of the program be brought back to the House at a special or regular session for final approval."

After extensive debate, Dr. Schreiber's motion was defeated.

By official action, the House voted to bring the debate on the Council's recommendations to a close. The President called for a standing vote on the motion of Dr. Wells to approve the recommendations of the Council, as stated by Dr. Wells, and the motion to adopt the recommendations was carried by a vote of 135 to 10.

REPORT ON COUNTERSUITS

Dr. Bates next introduced Dr. A. Burton Payne, Lawrence County, a member of the OSMA Task Force on Professional Liability, to report the following recommendations regarding countersuits:

Mr. President and Members of the House of Delegates, according to the research done to date by the Task Force, countersuit activities in Ohio have recently increased but no definitive action has yet happened. Ohio law and court rules require that a court case be finalized by withdrawal of the suit or dismissal before any countersuit may be initiated. These laws and rules are now being researched by OSMA legal counsel but the findings of that research will not be available for a few weeks yet.

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Proceedings of House (continued)

The Task Force hopes that, as a result of this research, legislation may be drawn up to allow a physician wrongly sued to initiate a countersuit at some earlier point in the litigation process.

Early data from Illinois shows a drastic decrease in the number of suits filed where a physician was successful in suing a plaintiff and counsel for not doing adequate investigation and research before filing a malpractice case. This data, while not conclusive by any means, supports the theory that the Task Force should continue its work in this area.

One of the ways the OSMA might help physicians decide whether some form of countersuit would be of benefit would be to provide review by OSMA legal counsel of specific cases submitted by members. This concept was approved by the House of Delegates last May when it passed Substitute Resolution 45-76 which calls for the OSMA to "establish a mechanism to advise, assist, and support Ohio physicians regarding countersuits against such party or parties who, in the opinion of OSMA Legal Counsel, have initiated baseless and frivolous professional liability proceedings." This review is available to any OSMA member and, like the research project, is being funded by the voluntary solicitation Dr. Bates spoke of earlier.

Mr. President, since the research project is now underway and the review mechanism is in place and available to OSMA members, it appears that this House of Delegates should reaffirm its resolve to investigate countersuits as called for by Resolutions 6-76 and 45-76 and that this House request a report at its next meeting, and,

Mr. President, I move the reaffirmation of Resolutions 6-76 and 45-76.



Left to right: C. Edward Pichette, M.D.; Donavin A. Baumgartner, Jr., M.D.; John J. Gaughan, M.D.; and George P. Leicht, M.D.

By official action, the House voted to **adopt** the countersuit recommendations.

Dr. Gaughan then submitted a list of 13 suggestions from the Caucus of the Fifth District for consideration in the formation of the professional liability insurance company. These were referred by the President to the Council.

Dr. Gaughan then submitted a statement, dated August 1, from the Fifth District Caucus, concerning countersuits. The statement included six procedures as suggestions. The statement was referred by the President to the Council.

Before adjournment, Dr. Bates thanked the members of the House as follows: "Members of the House, you have undertaken a significant project through today's

action. You are to be commended for your work here and on behalf of the Council, I thank you."

There being no further business, the House of Delegates then adjourned sine die.

ATTEST: Hart F. Page
Executive Director

proceedings of the council

August 1, 1976 — 8 AM

OSMA Council present: George N. Bates, M.D., Toledo, President; William M. Wells, M.D., Newark, President Elect; Maurice F. Lieber, M.D., Canton, Past-President; Robert G. Thomas, M.D., Elyria, Secretary-Treasurer; Stephen P. Hogg, M.D., Cincinnati, First District Councilor; W. J. Lewis, M.D., Dayton, Second District Councilor; Alford C. Diller, M.D., Convoy, Third District Councilor; C. Douglass Ford, M.D., Toledo, Fourth District Councilor; John J. Gaughan, M.D., Cleveland, Fifth District Councilor; C. Edward Pichette, M.D., Youngstown, Sixth District Councilor; Robert E. Rinderknecht, M.D., Dover, Seventh District Councilor; Richard E. Hartle, M.D., Lancaster, Eighth District Councilor; J. Hutchison Williams, M.D., Columbus, Tenth District Councilor; S. Baird Pfahl, Jr., M.D., Sandusky, Eleventh District Councilor; and William Dorner, Jr., M.D., Akron, Twelfth District Councilor. Absent: Thomas W. Morgan, M.D., Gallipolis, Ninth District Councilor.

Guests present: Thomas C. Coady, Esq., Columbus, Legal Counsel; James L. Henry, M.D., Grove City, Chairman, Task Force on Professional Liability; and A. Burton Payne, M.D., Ironton, Member, Task Force on Professional Liability.

OSMA Staff present: Hart F. Page, Executive Director



Robert R. Clark, M.D.

rector; Charles W. Edgar; Herbert E. Gillen; Robert D. Clinger; David L. Rader; D. Brent Mulgrew; Katherine E. Wisse; Robert E. Holcomb; Douglas J. Freeman; Linda A. Jacobson; and Rebecca J. Doll.

ANNOUNCEMENTS

A suggested original Board of Directors of the proposed Physicians Insurance Company of Ohio was presented by the Executive Director: Dr. Bates, Chairman; Dr. Wells, Vice-Chairman; Dr. Lieber; Dr. Thomas; Dr. Dunsker; Dr. Gaughan; Dr. Henry; Dr. Payne; Mr. Page; Mr. Pohlman; and The Insurance Company Chief Executive.

On a motion by Dr. Lewis, seconded by Dr. Pfahl, The Council voted to **approve** the suggested original Board of Directors.

ADJOURNMENT

There being no other business, the meeting was adjourned.

ATTEST: Hart F. Page
Executive Director

August 1, 1976 — 2 PM

OSMA Council present: George N. Bates, M.D., Toledo, President; William M. Wells, M.D., Newark, President Elect; Maurice F. Lieber, M.D., Canton, Past-President; Robert G. Thomas, M.D., Elyria, Secretary-Treasurer; Stephen P. Hogg, M.D., Cincinnati, First District Councilor; W. J. Lewis, M.D., Dayton, Second District Councilor; Alford C. Diller, M.D., Convoy, Third District Councilor; C. Douglass Ford, M.D., Toledo, Fourth District Councilor; John J. Gaughan, M.D., Cleveland, Fifth District Councilor; C. Edward Pichette, M.D., Youngstown, Sixth District Councilor; Robert E. Rinderknecht, M.D., Dover, Seventh District Councilor; Richard E. Hartle, M.D., Lancaster, Eighth District Councilor; J. Hutchison Williams, M.D., Columbus, Tenth District Councilor; S. Baird Pfahl, Jr., M.D., Sandusky, Eleventh District Councilor; and William Dörner, Jr., M.D., Akron, Twelfth District Councilor. Absent: Thomas W. Morgan, M.D., Gallipolis, Ninth District Councilor.

Guest present: Thomas C. Coady, Esq., Columbus, Legal Counsel.

OSMA Staff present: Hart F. Page, Executive Director; Charles W. Edgar; Herbert E. Gillen; Robert D. Clinger; David L. Rader; D. Brent Mulgrew; Katherine E. Wisse; Robert E. Holcomb; Douglas R. Houser; Douglas J. Freeman; Linda A. Jacobson; and Rebecca J. Doll.

The meeting was called to order by President Bates.

The Council voted to implement the instructions of the House of Delegates by forming the Physicians Insurance Company of Ohio and appointed the physician members of the proposed original Board of Directors as the incorporators thereof.

The Council also instructed the Staff to keep the House of Delegates informed of developments in connection with the insurance company through a weekly news bulletin.

The staff was congratulated on the implementation of the technical aspects of the operations of the House of Delegates.

ADJOURNMENT

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page
Executive Director

From the President:
Insurance Company Summary

On August 1, 1976, a Special Session of the OSMA House of Delegates authorized the formation of a medical professional liability insurance company to be owned by the OSMA and the physicians of Ohio. This authorization was given in the belief that a physician owned and controlled company will enjoy advantages through physician participation which a regular commercial company cannot enjoy. Chief among these advantages are the areas of risk management, claims management, and the establishment of underwriting criteria.

The Physicians Insurance Company of Ohio (PICO) is now being organized as a stock company pursuant to the insurance laws of the State of Ohio. PICO anticipates that stock will initially be offered for sale during the month of September 1976. *This offering of securities will only be made by means of an offering circular and will be sold through an Ohio broker-dealer.*

The purpose of the stock offering is to raise capital for the company. This will enable PICO to qualify for a Certificate of Authority from the Ohio Department of Insurance to write and sell insurance. The capital and surplus of PICO will be invested pursuant to laws covering such investments for insurance companies.

All purchasers of stock must be OSMA members who are practicing medicine and surgery or osteopathic medicine and surgery in Ohio under a license issued by the Ohio State Medical Board. In addition, purchasers must be either residents of Ohio or qualifying Ohio professional medical partnerships or corporations.

Two classes of stock will be issued: 12,000 Class A shares will be offered to individual physicians (or partnerships or corporations), while 100 Class B shares will be offered to the OSMA. These shares are identical except for voting privileges: Class A stock carries one vote per share; Class B carries 100 votes per share. Thus, when all 12,000 shares of Class A are sold, the OSMA will have 10,000 votes and OSMA shareholder/members will have 12,000 votes.

All physicians intending to purchase medical professional liability insurance from PICO must be stockholders in the Company. However, purchase of stock does not guarantee insurability as normal liability underwriting procedures will be followed for that determination.

George N. Bates, M.D.

(Proceedings continued on page 548)

OSMA House of Delegates

Attendance of Delegates

August 1, 1976 Special Session

COUNTY

DELEGATE

FIRST DISTRICT

ADAMS

BROWN

BUTLER

James M. Smith

CLERMONT

Carl A. Minning

CLINTON

Foster J. Boyd

HAMILTON

John E. Albers
Eugene J. Burns
Stewart B. Dunsker
George D. J. Griffin
Harry K. Hines
James Leonard
Stanley J. Lucas
H. Glenn Overley
Glenn W. Pfister
William J. Schrimpf
Andrew J. Weiss

HIGHLAND

WARREN

Tom Fox

SECOND DISTRICT

CHAMPAIGN

Isador Miller

CLARK

Robert McLemore
Ernest H. Winterhoff

DARKE

GREENE

Antonio D. Mannarino

MIAMI

A. Robert Davies

MONTGOMERY

John H. Boyles, Jr.
Thomas Garnica
Don E. Sando
Frederic C. Schnebly
John H. Taylor
John R. Whitaker, Jr.
John Worthman

PREBLE

SHELBY

George J. Schroer

THIRD DISTRICT

ALLEN

David A. Barr
Gene Wright

AUGLAIZE

David Neilson

CRAWFORD

HANCOCK

William H. Kose

HARDIN

Robert Elliott

LOGAN

MARION

Paul E. Lyon

COUNTY

DELEGATE

MERCER

James J. Otis

SENECA

Walter A. Daniel

VAN WERT

WYANDOT

FOURTH DISTRICT

DEFIANCE

H. C. Brown

FULTON

Benjamin H. Reed, Jr.

HENRY

LUCAS

John A. Devany
Frank Foss
Roland A. Gandy, Jr.
B. Leslie Huffman
M. Brodie James
Thomas J. O'Grady
Harry L. Snyder

OTTAWA

PAULDING

PUTNAM

James B. Overmier

SANDUSKY

WILLIAMS

WOOD

Douglas S. Hess

FIFTH DISTRICT

ASHTABULA

CUYAHOGA

Donavin A. Baumgartner, Jr.
Charles L. Cassady
Ronald Carlson
Theodore J. Castele
Henry A. Crawford
Gilbert Derian
Roscoe J. Kennedy
Edward G. Kilroy
Steven Kovacs
Vincent T. LaMaida
George P. Leicht
Leonard L. Lovshin
Leroy W. Matthews
Russell J. Nicholl
Richard J. Nowak
Thomas P. Paras
George W. Petznick
P. John Robecheck
Joseph Schultz
Franklyn J. Simecek
Frederick T. Suppes
Warner W. Tuckerman

GEAUGA

Frederick R. Mautz

LAKE

John A. Bukovnik
Wesley J. Pignolet

COUNTY	DELEGATE
SIXTH DISTRICT	
COLUMBIANA	William Banfield
MAHONING	J. J. Anderson Jack Schreiber William E. Sovik Joseph W. Tandatnick
STARK	Edward J. Davis Edward E. Grable Raymond J. McMahon, Jr. William A. White, Jr.
TRUMBULL	Joseph L. Logan Joseph Sudimack

SEVENTH DISTRICT	
BELMONT	
CARROLL	
COSHOCTON	Robert R. Johnson
HARRISON	Janis Trupovnieks
JEFFERSON	Irving Dreyer
MONROE	Donald R. Piatt
TUSCARAWAS	Benjamin J. Wherley

EIGHTH DISTRICT	
ATHENS	John F. Kroner
FAIRFIELD	
GUERNSEY	Robert A. Ringer
LICKING	John P. Anderson
MORGAN	
MUSKINGUM	Carl E. Spragg
NOBLE	
PERRY	
WASHINGTON	Gregory Krivchenia

NINTH DISTRICT	
GALLIA	Thomas P. Price, Jr.
HOCKING	Lethia Starr
JACKSON	John W. Zimmerly
LAWRENCE	A. Burton Payne
MEIGS	
PIKE	
SCIOTO	Chester H. Allen
VINTON	

TENTH DISTRICT	
DELAWARE	Adelbert R. Callander
FAYETTE	
FRANKLIN	Homer A. Anderson Michael A. Anthony Ben Arnoff Robert C. Atkinson Richard L. Fulton

COUNTY	DELEGATE
	Walter M. Haynes George W. Paulson H. William Porterfield
KNOX	James C. McLarnan
MADISON	
MORROW	David J. Hickson
PICKAWAY	
ROSS	J. S. McKell
UNION	John B. Ziegler

ELEVENTH DISTRICT	
ASHLAND	Jon Cooperrider
ERIE	Richard H. Williamson
HOLMES	Luther W. High
HURON	Nino M. Camardese
LORAIN	Delbert L. Fischer Henry E. Kleinhenz Thomas Sfiligoj
MEDINA	Rolland L. Mansell
RICHLAND	James F. Clements Harold F. Mills
WAYNE	A. Burney Huff

TWELFTH DISTRICT	
PORTAGE	F. Michael Sheehan
SUMMIT	Rocco Antenucci Charles V. Bowen Roy E. Bugay Robert R. Clark Joseph L. Kloss Emmett P. Monroe Fred F. Somma

OFFICERS	
President	George N. Bates
President-Elect	William M. Wells
Past President	Maurice F. Lieber
Secretary-Treasurer	Robert G. Thomas

COUNCILORS	
First District	Stephen P. Hogg
Second District	W. J. Lewis
Third District	Alford C. Diller
Fourth District	C. Douglass Ford
Fifth District	John J. Gaughan
Sixth District	C. Edward Pichette
Seventh District	Robert E. Rinderknecht
Eighth District	Richard E. Hartle
Ninth District	(Dr. Morgan not present)
Tenth District	J. Hutchison Williams
Eleventh District	S. Baird Pfahl, Jr.
Twelfth District	William Dorner, Jr.

TOTAL	145
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ephedrine/theophylline/glyceryl guaiacolate/phenobarbital



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PRECAUTIONS: With Bronkotabs therapy sympathomimetic side effects are minimal. However, frequent or prolonged use may cause nervousness, restlessness, or sleeplessness. Bronkotabs should be used with caution in the presence of hypertension, heart disease, or hyperthyroidism. Drowsiness may occur. Ephedrine may cause urinary retention, especially in the presence of partial obstruction, as in prostatism.

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Physicians who receive rebates from independent laboratories are in violation of Medicare law. These rebates are usually determined by the volume of test referrals made to the laboratory.

The Medicare law (42 U.S. Code 1395nn [b]) provides:

Whoever furnishes items or services to an individual for which payment is made or may be made under this subchapter and who solicits, offers, or receives any (1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or (2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

Although only a small number of physicians may be involved in the rebate practice, the criticism of the public is directed at everyone associated with this area of health care. The Department of Health, Education, and Welfare has indicated its intention to seek prosecution in any cases of such violation which come to light. The Department encourages physicians to report offers tendered to provide such rebates. To report such offers, Ohio physicians should contact Robert C. Green, Bureau of Health Insurance Regional Representative, 300 Wacker Drive, Room 2800, Chicago, Illinois 60606. Telephone: 312/353-5585.

Hospitals Now Required To Offer Uterine Cytologic Exam

Effective August 24, 1976, every hospital in Ohio is required by statute to offer a uterine cytologic examination for cancer to every female in-patient 20 years of age or older. The new statute, H.B. 1000, Panehal (D-

Cleveland), requires hospitals to offer this medical procedure whether or not the procedure is medically indicated.

The patient's attending physician may order that the test *not* be given if he feels it is not advisable medically. In such cases, the physician should note on the patient's hospital chart (eg, in the progress notes) that the test was inadvisable and then date and sign the entry in the chart.

The patient also retains the right to refuse the test when it is offered by the hospital even before the physician makes a determination whether or not it is inadvisable. The best procedure for the hospital would be to have the patient affirmatively state and sign a refusal of the test. In this way, a record is made to substantiate both the offering of the test by the hospital and its rejection by the patient.

If the patient requests the examination, a physician must order the test performed. The order should be written in the patient's medical chart and the results attached to the chart also. The new law requires that the hospital maintain records showing whether or not the examination was performed, any ensuing results, and/or a patient's refusal.

If the above procedures are followed, the records required by the new law can be easily kept without a great deal of inconvenience to the patient, the hospital, or the physician.

Ohio Division of Am. Cancer Soc. To Hold Annual Symposium

The Ohio Division of the American Cancer Society will hold its Annual Cancer Symposium on Tuesday, October 12, at the Fawcett Center for Tomorrow, Columbus. "Recent Advances in Childhood Cancer" is the topic for the conference.

(continued on page 557)



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Awards Presented to 25-Year Team Physicians

The Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association and Ohio High School Athletic Association honored 17 Ohio physicians for outstanding service to scholastic athletic teams and the field of sports medicine at the annual Ohio High School Football Coaches Hall of Fame Banquet held in August. The banquet occurred in conjunction with the sixth Postgraduate Institute on Sports Medicine cosponsored by OSMA, The Ohio State University College of Medicine, and the Ohio High School Athletic Association. Each of these gentlemen has performed as a team physician for at least 25 years. The remarks about each physician are those attributed by his school.

SOL MAGGIED, M.D., West Jefferson, received the 1976 Special Award for Outstanding Contributions to Sports Medicine in Ohio. In presenting the award, the OSMA said of Dr. Maggied:

He has been an active member of the Joint Advisory Committee on Sports Medicine since its inception in 1960. He served as chairman from 1969-1974. During his time of leadership, the Committee became a dynamic force in conducting inservice training programs in sports medicine for team physicians, athletic trainers, coaches and officials throughout Ohio. With his encouragement, the Committee began offering medical coverage for tournaments in several sports sponsored by the Ohio High School All-Stars beginning last year. Dr. Maggied has always been prepared to promote sports medicine almost at a moment's notice. He has appeared often before such outstanding groups as the Ohio Association for Health, Physical Education and Recreation, Section on Sports Medicine of the Ohio State Medical Association, and rules interpretation meetings for coaches and officials. During his 16 years on the Committee, he has never submitted an expense account for his travels around the state and numerous hours spent in pursuing his "labor of love."

The members of the Joint Advisory Committee on Sports Medicine are honored to present this special award to Sol Maggied, M.D. —a special person whose dedication to the cause of health and safety of our young athletes is unexcelled.



Left to right: Coach Woody Hayes of The Ohio State University Buckeyes and Sol Maggied, M.D., recipient of the 1976 Special Award for Outstanding Contributions to Sports Medicine.

Also Honored:

JAMES M. ANDERSON, M.D., team physician for Lemon-Monroe High School, Monroe: "He not only fixes physical ills but helps comfort many people after injury. The special concerns he displays for athletics and the people involved makes him deserving of this special accolade."

WILLIAM T. BACON, M.D., team physician for London High School, London: "Classified as a super fan, super doctor and good friend to all of London's sports programs. He is constantly advising the athletic department and school administrators of the newest techniques and information regarding sports medicine."

WILLIAM S. BANFIELD, M.D., team physician for Stanton High School, Irondale: "Dr. Bill provides the students of Stanton High School with an invaluable and nonmeasurable medical service. Our community is grateful and richer for having him."

E. J. DAVIS, M.D., team physician for East Canton High School, East Canton: "He is not only a friend to athletes on the field, but an influencing friend to see athletes and students further their education. He gives time to explain injuries and their relation to the sports so that a coach would not play anyone who could suffer permanent damage."

ROBERT H. HINES, M.D., team physician for Minerva High School, Minerva: "We have been blessed to have the service, friendship and close association with this man who in our opinion is one of the greatest, most unselfish human beings we've ever known."

GEORGE R. HOEFLINGER, M.D., team physician for Hilliard High School, Hilliard: "He has not only given his professional talents, but perhaps his most valuable asset—his time. It is this type of unselfish attitude that makes a high school athletic program safe and enjoyable. We have great confidence in his judgment and ability."

A. J. KARSON, M.D., team physician for Medina High School, Medina: "We couldn't ask any more from a team physician than we get from Dr. Karson. For example, at 11:00 AM on a Friday last fall, he was in Oregon on vacation. At 8:00 PM, he was on the sideline for our home football game."

ROBERT G. KING, M.D., team physician for Alliance High School, Alliance: "He went far beyond the call of duty to make sure that not only were injured athletes given the very best of care, but that his preventive approach to an athlete's well being was such that anything that could be done was done."

(continued on page 554)

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Team Physicians Honored

(continued from page 552)

DONALD F. KYLE, M.D., team physician for Cedarville High School, Cedarville: "The unselfish contribution of time by Dr. Kyle toward the health and welfare of the youth of the community deserves this award—and more. He quietly serves his community in many ways—and the recipients are often unaware of the source."

DAVID J. LEVY, M.D., team physician for South Range, Lima; Campbell Memorial, Campbell; Youngstown North and Youngstown Rayen High Schools, Youngstown: "His service leaves an indelible mark on our community. His greatest concern is for the welfare of the individual. We are particularly grateful for his support, ideas regarding training, and treatment of our athletes."

A. J. MARTIN, M.D. (deceased), team physician for Buckeye West High School, Adena: "Everyone in our community, school and surrounding area admired this man. He never missed a game. He gave of his time for the sole purpose of wanting to see youngsters achieve a better way of life."

HAROLD G. OVERLEY, M.D., team physician for Mariemont High School, Mariemont: "His willingness to help makes him unique within the school district. Along with serving on the field, he has treated our athletes willingly and skillfully in his office. Recognition for his efforts is richly deserved."

SANFORD PRESS, M.D., team physician for Steubenville High School, Steubenville: "He is honored, esteemed and loved by Steubenville. He has unhesitatingly responded to every need of every athlete in every sport since he entered practice. A great innovator, he has also added incomparably to the science of caring for specific injuries."

ROBERT E. REIHELD, M.D., team physician for Orrville High School, Orrville: "The most rewarding part of his contribution is the positive, pleasant manner in which he volunteers his time and efforts. He treats injured athletes at any time of day or night. There are few if any who support a local athletic program more than Dr. Reiheld."

WILLIAM B. RUNDENMILLER, M.D., team physician for Cincinnati Elder High School, Cincinnati: "Nowhere does his selfless dedication manifest itself more than in the care of our 600 plus athletes participating in interscholastic athletics. His generosity to others has often been at the sacrifice of his own time and even of his health."

ROBERT S. YOUNG, M.D., team physician for Johnstown-Monroe High School, Johnstown: "Everyone associated with the athletic program plus the school administration and fans throughout the community salute this energetic physician who devotes countless hours beyond his regular medical practice to the health and welfare of our youth."

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A. C. Spath, Jr., R. A. Zimmerman
COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: Suite 221, 5241 Southwyck Blvd., (419) 865-5215, R. E. Stallter

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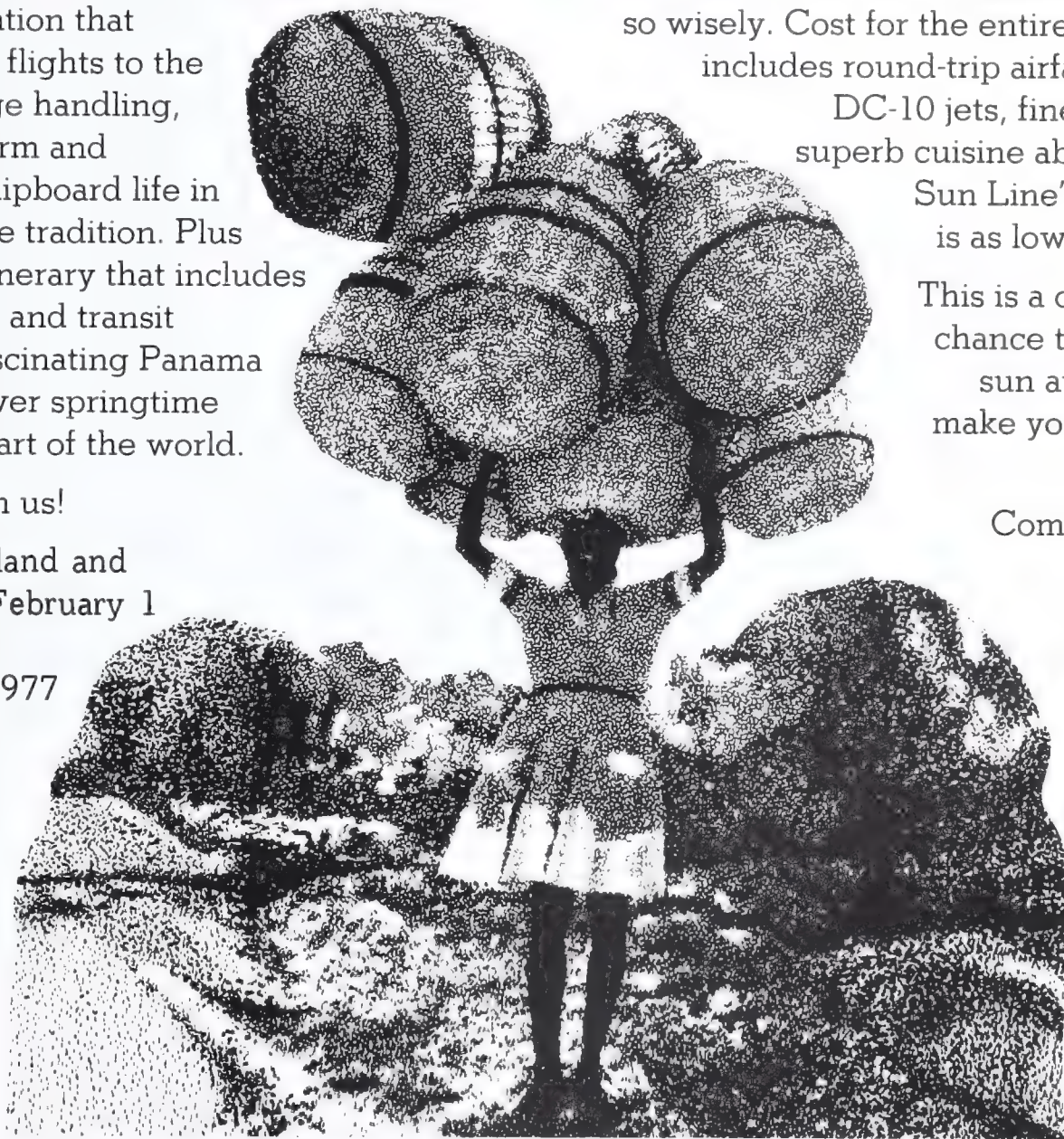
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1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Guilio D'Angio, M.D., Director of the Comprehensive Cancer Center at the University of Pennsylvania and the Children's Hospital of Philadelphia, will speak about forms of children's tumors which are showing exceedingly encouraging therapeutic results and forms which have very significant cure rates. Dr. D'Angio is also Chairman of the Clinical Cancer Investigative Review Committee of the National Institutes of Health, National Cancer Institute.

Describing the multidiscipline approach to care of the child with cancer will be Gussie Higgins, M.D., Head of the Oncology Division, Department of Pediatrics, University of Southern California at Children's Hospital, Los Angeles. Dr. Higgins is in charge of the Los Angeles-area program which is designed to provide care for children with cancer, specifically leukemia, utilizing resources in the community as well as the multidiscipline resources at the hospital.

Beatrice Lampkin, M.D., Head, Division of Hematology/Oncology, Children's Hospital of Cincinnati, will cover up-to-date chemotherapy management of leukemic children.

The program will conclude with a tumor board panel discussion moderated by Samuel Gross, M.D., Professor of Pediatrics and Director of Pediatric Hematology and Oncology, University Hospitals of Cleveland.

Medical Board Must Give Alleged Violators Rights of Due Process

The State Medical Board is governed by the Administrative Procedure Act (Chapter 119, Revised Code). When an alleged violation of the Medical Practice Act (Chapter 4731, Revised Code) occurs, the physician or limited practitioner cannot have his license summarily taken away. He must be afforded the rights of due process provided by the Constitution and by the Administrative Procedure Act. Action cannot be taken on hearsay or innuendo.

Any complainant, including medical societies, should furnish the Board with names of witnesses and firsthand information if it is available. The licensee must be given formal notice of the alleged violation, and he has 30 days in which to request a formal hearing.

When a hearing is requested, a time must be set and the licensee given a full opportunity to present his side or position concerning the alleged violation. It should be noted that the licensee may request a continuance of the hearing date for good cause and a reasonable extension of time must then be given to avoid due process procedural problems. He is entitled to be represented by counsel, and he may present evidence and examine witnesses for and against him. A formal record is made at the adjudication hearing. Many times the hearing extends over many days because of the complexities of the evidence and law

involved. After the hearing, the State Medical Board has to reach a decision.

Once the decision is reached, the licensee must be formally notified of the decision. If the decision is adverse to the licensee, he has the right to appeal to the Court of Common Pleas and has certain appellate rights which go to the Court of Appeals, the Supreme Court of Ohio, and the Supreme Court of the U.S. During the appeal, the licensee has a right to continue to practice if he can show undue hardship to the Court; and frequently, this right is granted. The Courts may only sustain the decision of the Board if the decision is in accordance with law and is supported by reliable, probative, and substantial evidence (testimony of firsthand witnesses whether patients, practitioners or others), not by rumor nor secondhand complaint.

From January 1, 1976 to July 1, 1976, thirty-one individuals have been asked to appear at the Board offices to discuss potential violations of law. Sixteen of these individuals were doctors of medicine. During this period, the Medical Board has held two formal hearings with seven more pending.

There have been nine arrests during 1976 for the illegal practice of medicine, all of which are still pending before the courts. Of the four criminal cases which were still pending at the end of 1975, two have resulted in conviction and two are still pending.

Since the beginning of 1976, there have been eight voluntary surrenders of medical licenses and two voluntary surrenders of Drug Enforcement Administration (D.E.A.) registrations, all by doctors of medicine.

(continued on page 558)

Looking for Quality Antiques?

For Office, Home,
or Investment

Visit

New Columbus Show

September 16-19

11 AM - 10 PM, Sunday 11-6

State Fairgrounds

Buckeye Building

I-71 exit at 17th Avenue

100 dealers from Pennsylvania,
New England, and the South

Early furniture and accessories

Everything Guaranteed
Quality Controlled

Crutcher Managed

Scioto County Plans Med. Seminar

The Scioto County Medical Society will conduct its seventh annual postgraduate medical seminar at the Shawnee State Park Lodge, Portsmouth, October 8, 9, and 10. Entitled "Current Therapy VII," the seminar is acceptable for 7½ hours of credit by the American Academy of Family Physicians. Faculty members include physicians from Creighton University, Johns Hopkins University, The Ohio State University, and the University of Cincinnati. For further information contact L. E. Thompson, Executive Secretary, Scioto County Medical Society, telephone: 614/354-5315.

Category I CME Courses Will Be Listed in Section of *The Journal*

The Continuing Medical Education feature of *The Journal* will return to the publication as of the November 1976 issue. This section will limit listings to courses approved for **Category I credit**.

Any organizations wishing to list courses should send the following information no later than **90 days**

prior to the date of the course: title; date(s); location; place, address, city; for what medical area the course is designed; sponsor (cosponsor, if any); hours of Category I credit; registration fee; and person to contact for further information.

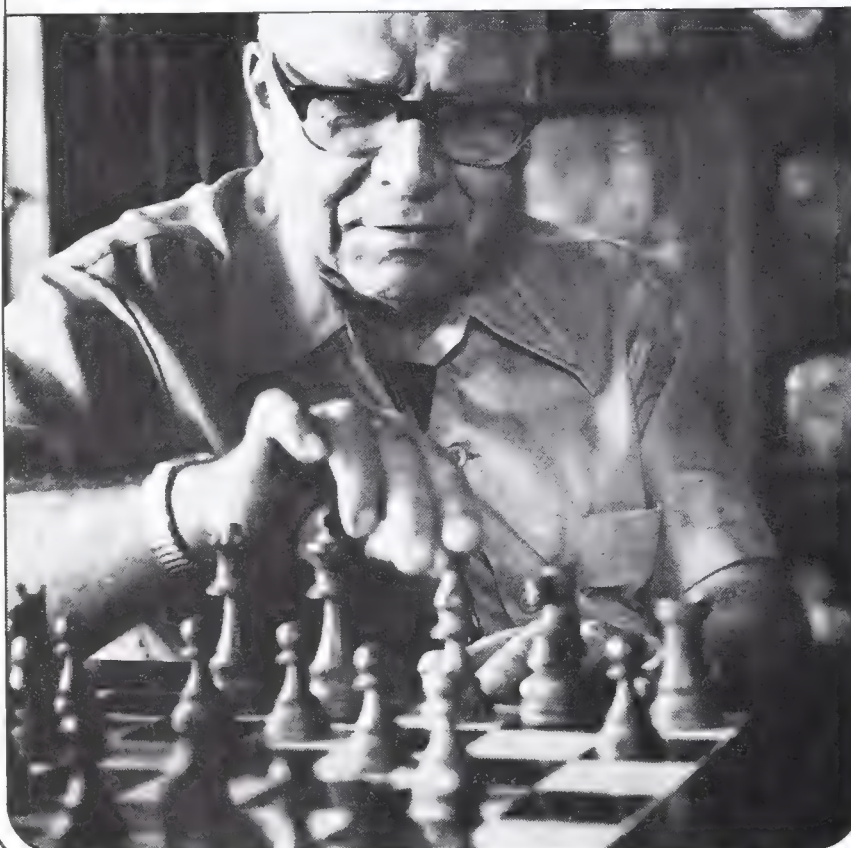
Send this information to the OSMA Commission on Medical Education, 600 S. High St., Columbus 42315.

OSU Physician President of Miss Wheelchair America Pageant

Ernest W. Johnson, M.D., Chairman of the Department of Rehabilitative Medicine at The Ohio State University College of Medicine, is this year's president of the Miss Wheelchair America Pageant. The pageant will be held in Columbus, September 25. Ohio's entrant is Miss Carol Sue Cyrus, a lady who was featured in the article, "Creative Living: A Bright Future for the Quadriplegic," *The Journal*, Volume 72, Number 2 (February 1976). Miss Cyrus was judged on accomplishments made since her disability, her personality, and her appearance in winning the Miss Wheelchair Ohio title. She is currently a student at The Ohio State University majoring in counseling and rehabilitation.

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

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FORGETFULNESS • CONFUSION**



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STIMULANT & VASODILATOR
FOR GERIATRIC PATIENTS**

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Pentylentetrazole 100 mg. • Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg. • Thiamine HCl 25 mg.
L-Glutamic Acid 50 mg. • Niacinamide 5 mg.
Riboflavin 2 mg. • Pyridoxine HCl 3 mg.

AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
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2500 W. 6th St., Los Angeles, Calif. 90057

Medicare Law Guides MDs Billing Cost of Independent Lab Tests

Medicare reimbursement rules require that the reasonable charge for a laboratory test that was performed by an independent laboratory, but billed by the attending physician, be related to the cost the physician incurred in obtaining the service for his patient. The Medicare carriers are permitted to allow as reasonable a nominal charge by the physician for the drawing of specimens and handling expenses. However, charges representing merely a physician markup of the charges over and above that actually imposed by an independent laboratory for the test itself are improper. Moreover, an independent laboratory not certified to perform a given test under Medicare may not be reimbursed with Medicare funds even though that test is billed through a physician.

In carrying out their responsibilities, Medicare carriers are required to determine the source of the lab service when the source is not indicated on the physician's bill. Where the service was performed by an independent lab, the carrier must determine that the laboratory is certified

by Medicare to perform such tests and the appropriate payment to cover the laboratory's customary charge, rather than the physician's.

Review of Medicare claims indicate that some physicians continue to submit bills for lab tests without showing that the services were actually performed by independent laboratories. We think that it is essential that all of your members are apprised of and understand Medicare requirements, and that there be full disclosure by a physician concerning the source of tests for which payment is claimed under the program. Our aim is to avoid the possibility of physician billing in a manner that could have serious legal consequences.

If you would like us to assist in the preparation of informational materials on this subject, or if you have any questions, please do not hesitate to contact us.

Thomas M. Tierney
Director
Bureau of Health Insurance
Department of Health,
Education, and Welfare
Social Security Administration
Baltimore, Maryland 21235

**COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT
ON STANDING**

LIPO-NICIN

A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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COLLEAGUES IN THE NEWS . . .

ELIZABETH R. APLIN, M.D., has retired as Chief of the Bureau of Crippled Children's Services of the Ohio Department of Health. Dr. Aplin practiced medicine for 20 years in Gnadenhutten after receiving her medical degree from Case Western Reserve University. During this period, she served a three-year term as Tuscarawas County Health Commissioner. Before her appointment as Chief of the Bureau of Crippled Children's Services, she was Director of Pediatric Services of the Reception and Diagnostic Center of the Columbus State Institute.

JACOB S. ARAJ, M.D., Maumee, has been named a Fellow of the American College of Radiology. Dr. Araj is affiliated with Medical College, Wood County, and Heller Memorial Hospitals and Toledo Mental Health Center.

CHESTER A. BENNETT, M.D., Dover, was honored at the July meeting of the Tuscarawas County Medical Society. Dr. Bennett, who has retired from active practice, was presented a plaque bearing the following inscription: "Given to Dr. Chester A. Bennett in recognition of devoted service to the community 1933-1976."

JANET K. BIXEL, M.D., Worthington, has been named a Fellow of the American College of Physicians. Dr. Bixel is an endocrinologist.

DAVID CLYMER, M.D., Lexington, has been honored by the Lexington Chamber of Commerce as 1976 Father of the Year. Dr. Clymer, a family physician, is a Fellow of the American Academy of Family Physicians, Secretary-Treasurer of the Richland County Academy of Family Physicians, and Secretary of the Mansfield General Hospital Staff.

INGRID DAOUD, M.D., Cincinnati, has been appointed Medical Director for the Clermont County Diagnostic Clinic. Dr. Daoud, who has served as Assistant Professor of Pediatrics at the University of Kentucky, is a pediatrician at Good Samaritan Hospital.

JOHN U. FAUSTER, JR., M.D., Defiance, has been recognized by the Ohio Senate for his 50 years of active professional service. Members of the Senate of the 111th General Assembly of Ohio passed a resolution, sponsored by Senator M. Ben Gaeth, which stated in part: "We members of the Senate in passing this resolution offer our highest praises to Dr. Fauster and in so doing, recognize one of Ohio's most outstanding physicians and citizens."

JOSEPH A. FERGUS, M.D., St. Paris, was honored by the community for his 40 years in practice there. Approximately 1,400 people attended the event with the master of ceremonies being U.S. Representative Clarence B. Brown (R-Urbana), Seventh Congressional District. During this program, it was reported that over \$4,000 has been donated in Dr. Fergus' name for emergency equipment for the Johnson-St. Paris Rescue Unit.

RICHARD B. FRATIANNE, M.D., Cleveland, received a 1976 Applause Award given to Greater Clevelanders who have made important contributions to the betterment of life in the city. Dr. Fratianne established a burn center at Cleveland Metropolitan General Hospital.

GEORGE W. HORST, M.D., Bellefontaine, is the new Logan County Health Commissioner. Dr. Horst, who holds a master's degree in public health in addition to his medical degree, is a pediatrician. His experience includes two years with the General Practice Mission Service to the Navajo Indians of New Mexico and Arizona.

ROBERT L. JENKINS, JR., M.D., Youngstown, has been reelected First Vice-President of the Mahoning County Unit of the American Cancer Society. A past president of the Medical Staff of the Youngstown Hospital Association, Dr. Jenkins is a diplomate of the American Board of Internal Medicine and a member of the American College of Physicians, the New York Academy of Sciences, the American Geriatric Society, the National Rehabilitation Association, and the American Society of Internal Medicine.

ROBERT E. JEWETT, M.D., has been named Associate Dean for Academic Affairs at Wright State University School of Medicine. Dr. Jewett, who will also hold the rank of Professor in the Department of Pharmacology, is currently Dean of the College of Medicine at East Tennessee State University. He is a member of numerous professional societies including the American Society for Pharmacology and Experimental Therapeutics.

JAMES A. KEMP, M.D., Gallipolis, has been appointed Gallia County Health Commissioner. Dr. Kemp, who holds certification with the American Board of Internal Medicine, has served on the Gallia County Board of Health since 1970. In addition, he has been president of the Gallia County Medical Society and is a member of the Board of Trustees of Rio Grande College. He is also a member of the American College of Physicians and the American Federation for Clinical Research.

PAUL KEZDI, M.D., Director of the Cox Heart Institute in Dayton, has been named Associate Dean for Research Development and Professor of Medicine in the School of Medicine at Wright State University. He will continue to serve as Director of the Institute. A Fellow of the American College of Cardiology and the American

College of Chest Physicians, Dr. Kezdi is listed in *Who's Who in America* and *American Men and Women of Science*.

ADELAIDE W. KOESTNER, M.D., has been appointed Assistant Professor of Pathology at The Ohio State University College of Medicine. Dr. Koestner is the most recent recipient of the Zimmermann Fund of the American Medical Woman's Association. This fund is designed for the purpose of retraining women physicians who have, for one reason or another, not participated full-time in their chosen specialties.

BEATRICE LAMPKIN, M.D., Cincinnati, has been named the nation's Outstanding Woman in Medicine for 1976 by the National Board of the Medical College of Pennsylvania. The Medical College of Pennsylvania, whose National Board includes Mrs. Dwight D. Eisenhower and Mrs. Lyndon B. Johnson, chose Dr. Lampkin for her "valuable and significant research which has added so much to the knowledge of leukemia and its treatment." Dr. Lampkin is Director of the Hematology-Oncology Division at Children's Hospital Research Foundation, Professor of Pediatrics at the University of Cincinnati College of Medicine, and Director of the Hematology Clinic at Children's Hospital.

FRANK LINDSAY, M.D., Homeworth, has been honored for his service to the community. Dr. Lindsay has been the town's only physician for the past 36 years. He interrupted his practice to enlist in the Air Force and was awarded the Bronze Star as a flight surgeon "in recognition of meritorious service supporting tactical operations against the enemy in Korea."

ROBERT LITTLEJOHN, M.D., Barberton, has been appointed to the Board of Health. Dr. Littlejohn served as Barberton Health Commissioner for eight years before resigning to devote full time to his medical practice.

MAXWELL W. LIVINGSTON, M.D., Sunbury, has been named Honorary Citizen of the community. Dr. Livingston has practiced in the area for 35 years and is a member of the American and Ohio Academies of Family Physicians.

DOUGLAS LONGENECKER, M.D., Associate Professor and Chairman of the Department of Family Practice at Wright State University School of Medicine, was recently promoted to professor. Dr. Longenecker was Director of Family Practice at Riverside Methodist Hospital in Columbus before joining Wright State in 1974.

LEO LUTWAK, M.D., is the new full-time, hospital-based Chairman of the Department of Medicine, Akron City Hospital. Dr. Lutwak most recently has served as Professor of Medicine, University of California at Los Angeles School of Medicine; Professor of Nutrition,

School of Public Health, UCLA; and Chief, Division of Endocrinology, Nutrition, and Metabolism, Veterans Administration Hospital, Sepulveda, California.

A Fellow of the American College of Nutrition and the American Institute of Chemists, Dr. Lutwak holds professional memberships in the American Association for the Advancement of Science, American Diabetes Association, American Federation for Clinical Research, Western Society for Clinical Research, Society for Experimental Biology and Medicine, Endocrine Society, American Society of Clinical Nutrition, and American Physiological Society. He is also a member of the editorial board of the *American Journal of Clinical Nutrition*.

WILLIAM A. MILLHON, M.D., Columbus, Chairman of the Riverside Hospital Department of Medicine and Associate Clinical Professor at The Ohio State University, has been reelected to the Board of Trustees of the American Society of Internal Medicine.

The Medical Staff of Parma Community General Hospital, Parma, has elected officers for 1976: **THOMAS P. PARAS, M.D.**, president; **ROBERT E. BROOKS, M.D.**, vice-president; **JACK V. WISE, M.D.**, secretary; and **LOUIS L. KEPPLER, M.D.**, treasurer. The first member-at-large is **RICHARD SCHROEDER, M.D.**, and the second member-at-large is **ELMER RAUS, M.D.**

R. BRYAN ROBERTS, M.D., has joined the Wright State University School of Medicine as Professor and Chairman of the Department of Anesthesiology. He has served since 1968 as Professor of Anesthesiology and Associate Professor of Obstetrics and Gynecology at Mount Sinai School of Medicine of the City University of New York. Dr. Roberts is a Fellow of the Royal College of Surgeons of England and holds memberships in many other professional organizations, including the American Society of Anesthesiologists.

MORRIS S. ROSENBLUM, M.D., Youngstown, received a Distinguished Service Award at the summer commencement exercises of The Ohio State University. The award was presented for exceptional efforts on behalf of the university. Dr. Rosenblum has served as president of both the Medical Alumni Association and the Mahoning County Chapter of The Ohio State University Alumni Association. He is a member of the Alumni Advisory Board and has also been active in county development fund campaigns.

JOHN P. SCHLEMMER, M.D., Director of West Side Family Practice Center of Akron General Medical Center, has been named Chairman of the Council of Chiefs of Family Practice at Northeastern Ohio Universities College of Medicine.

Dr. Schlemmer was in private practice in Bath from 1959 to 1970. He has been Director of the Family Practice

(continued on page 564)



RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

**special report
Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

**The Common Denominator
of Health Progress
RESEARCH**

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

COLLEAGUES IN THE NEWS . . .

(continued from page 651)

Residency Program of Akron General Medical Center since 1970.

Dr. Schlemmer is a member of the Ohio and American Academies of Family Physicians, the Society of Teachers of Family Medicine, and the Association of Hospital Medical Educators.

LYNN A. SMITH, M.D., Painesville, a general practitioner at Lake County Memorial Hospital, has been appointed to the city health board.

ROBERT SMITH, M.D., Director of the Department of Family Medicine at the University of Cincinnati College of Medicine, is the first family practice educator in the U.S. to be made a Fellow of the Royal College of General Practitioners.

ROBERT E. TSCHANTZ, M.D., Canton, has been elected to an unexpired term on the Board of Trustees of the Greater Canton Chamber of Commerce. An OSMA Past-President, Dr. Tschantz is Chairman of the AMA Committee on Private Practice. In 1973, he was the recipient of the Greater Canton Chamber of Commerce's Award of Appreciation for "service of lasting benefit to the community."

J. DOUGLAS VEACH, M.D., Worthington, has been appointed to the Advisory Council of the Board of Nursing Education and Nurse Registration by Governor James Rhodes. Dr. Veach is Chief of Obstetrics at St. Ann's Hospital, Columbus.

FRANK VECCHIO, M.D., Cleveland Heights, has been selected by his fellow surgeons to receive the first St. Vincent Charity Hospital Distinguished Surgeon Award. Dr. Vecchio served as Chief of Surgery at St. Vincent for 15 years and was elected to two consecutive terms as president of the hospital's medical staff.

RICHARD A. WELSH, M.D., Lancaster, has been named a Fellow of the American College of Radiology. Dr. Welsh is affiliated with Lancaster-Fairfield County, Hocking Valley Community, and Mt. St. Mary Hospitals.

EUGENE WINKELMAN, M.D., Cleveland, has received the Cleveland Clinic Foundation Board of Trustees Award for Outstanding Community Service. Dr. Winkelman's award was presented "for service as a physician in providing primary and specialty care and enhancing the quality of care to patients of the Hough Norwood Family Health Care Center."

Comprehensive Group Health Care Plan

(Winston-Salem, North Carolina)

A new prepaid group health plan (Multi-specialty) opened July, 1976, for employees of R.J. Reynolds Industries, Inc. Assured growth, continuing expansion. The following board-qualified specialists are needed:

INTERNISTS PEDIATRICIANS
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This represents an opportunity to practice under ideal conditions in modern new facilities and excellent hospitals. Medical school environment.

Winston-Salem is located in the Piedmont section of North Carolina and is within reasonable driving distances to the Atlantic Ocean and Blue Ridge Mountains. The city is noted for its cultural, recreational, and college environments.

Salary commensurate with experience. Liberal fringe benefits including paid vacation, CME, retirement, life insurance, and health coverage. Malpractice insurance paid. Relocation expenses paid.

Send curriculum vitae, including salary requirements to:

Reid Bahnson, M.D.
Medical Director
W-S HEALTH CARE PLAN, INC.
250 Charlois Blvd.
Winston-Salem, North Carolina 27103

Winston-Salem Health Care Plan Inc.

An Equal Opportunity Employer M/F

Classified Ads

Rates: \$2.00 per line. Display classified: \$4.00 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat \$5.00 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 5th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, **The Journal**.

To assure prompt delivery, when replying to an advertisement over a **Journal** box number, address letters as follows: Box (insert number), c/o **The Ohio State Medical Journal**, 600 South High Street, Columbus, Ohio 43215.

NURSE ANESTHETISTS: Two immediate openings. Must be CRNA's. To work in an academic department, opportunity to teach, and continuing education. For interview apply: Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland, Ohio 44109. Phone 216/398-6000 ext. 4362.

EMERGENCY ROOM PHYSICIANS: Four-man Emergency Incorporated group seeking two additional full-time physicians. Negotiable salary plus paid liability insurance. Ohio license required. Positions open immediately. Please address resumes to: Necdet Orhon, M.D., 2066 Northridge Dr., Springfield, Ohio 45504, or call evenings 513/399-9663.

ORTHOPEDIC SURGEON WANTED: Boards or eligibility. Northwest Ohio Lake Erie vacation land. Close to medical centers. Very active practice including prosthetic and back surgery, incorporated practice with plans. Reply Box 774, c/o Ohio State Medical Journal.

PHYSICIAN, Board Eligible in Pediatrics and Preventive Medicine, desires position in central or northeast Ohio. Prefers position with a health department which would include some clinical pediatrics. Contact: Peter D. Rogers, M.D., M.P.H., Cedar Hill North, 651 Pineridge, Raleigh, North Carolina 27609. Telephone: 919/829-3419.

EMERGENCY PHYSICIAN: Columbus, Ohio. Established EM group with extensive continuing education plans needs an additional physician to improve staffing. Prefer physician who will have completed rotating internship by June 1976, with career orientation. Could accept qualified applicant for one year, July '76 - June '77. Busy EM practice in 600-bed, private teaching hospital with University affiliation (Mount Carmel Medical Center) and 250-bed private suburban hospital with 24-hour medical and surgical in-house coverage (Mount Carmel East Hospital). Must have Ohio license. At least 4 weeks vacation. Excellent starting income, meeting expenses, plus malpractice, hospitalization, disability and life insurance. Call Donald T. Evert, M.D., President, Emergency Services, Inc., 5979 E. Livingston Ave., Columbus, Ohio 13227, (614) 864-0566, 8:30 AM - 5:00 PM, Monday through Friday.

PHYSICIANS WANTED: LaFollette Community Hospital, LaFollette, Tennessee, is seeking an emergency room physician for immediate placement. Also, in need of family practice physicians, OB-GYN, and pediatricians. Guaranteed \$30,000 per year. Completely furnished office building adjacent to hospital. Located in East Tennessee, 45 miles north of Knoxville. Contact J. B. Wright, Administrator, LaFollette, Tennessee 37766. Telephone 615/562-2211.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartsville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallow Agency, Canton, Ohio 216/456-3495 or inquire of R. K. Loeffler, M.D., 430 Lake Avenue, N.E., Massillon, Ohio 44646.

EMERGENCY PHYSICIANS URGENTLY NEEDED: Low-volume or busy E.R.'s. Salary or percentage up to \$78,000 per year. Work two full days, off five, earn up to \$55,000. Reply Box 775 c/o Ohio State Medical Journal.

FAMILY PRACTICE OFFICE FOR RENT: Retiring physician wishes to rent office in small professional building. \$350 per month including utilities (cut to \$250 after discussion of equipment sale). Three completely equipped treatment rooms; one that can be so used. Large, beautifully furnished waiting room. Luxurious consultation room. All equipment, injectables, new EKG. Ready-made, very successful solo practice. Contact: Charles B. Trammont, M.D., 110 E. Gambier St., Mount Vernon, Ohio 43050. Telephone: 614/392-6961.

IMMEDIATE NEED — PRIMARY CARE PHYSICIAN: Part-time or full-time. A unique practice with three offices serving rural, urban and suburban communities. Appropriate compensation. Send resume to Sycamore Professional Association Inc., 8234 Winton Rd., Cincinnati, Ohio, 45231.

DIRECTOR MEDICAL EDUCATION: Excellent full-time opportunity for New Jersey-licensed MD to supervise all phases of medical education. Teaching and organizational experience essential. Active 360-bed general hospital near lovely lake country. Top salary and benefits. Send complete C.V. to Dr. William Pomerantz, Dover General Hospital, Jardine Street, Dover, N.J. 07801.

AN EQUAL OPPORTUNITY EMPLOYER

EMERGENCY ROOM GROUP: Central Ohio Hospitals—moderate volume, competitive remuneration and fringe benefits; contact Doctors Cooper, Spurgeon or Greenberg 1-800-325-3982.

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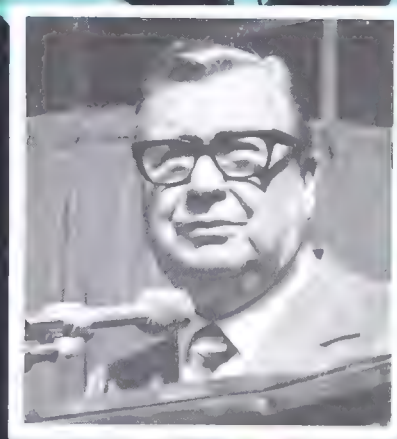
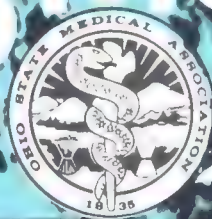
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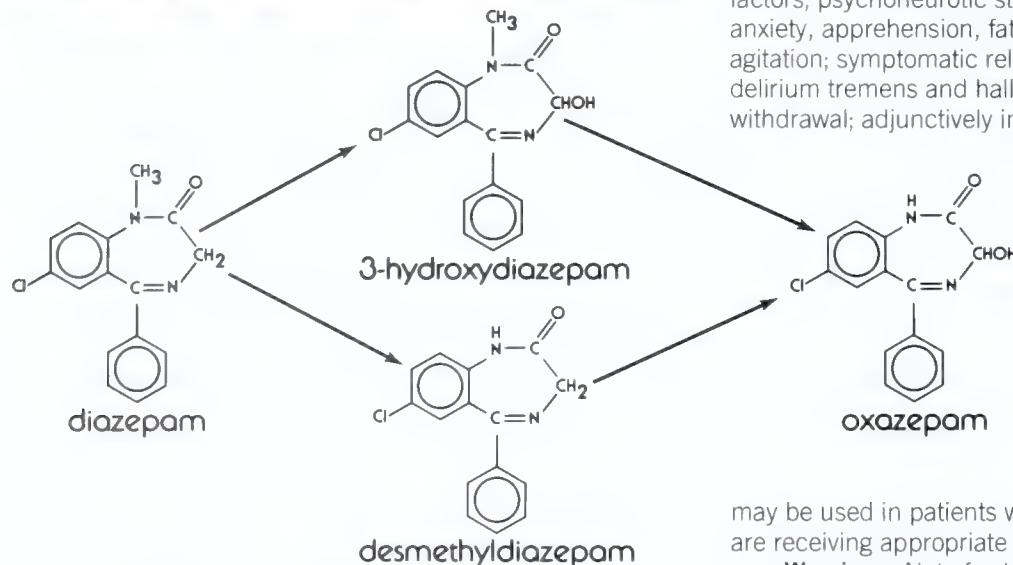
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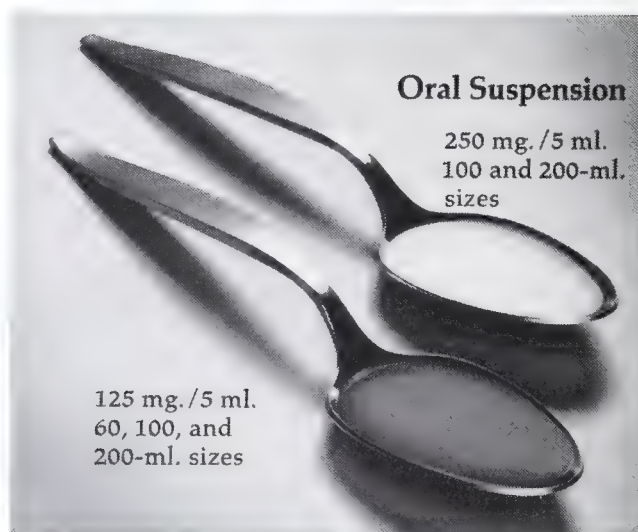
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COVER: Henry G. Cramblett, M.D., Dean of The Ohio State University College of Medicine, and James A. Rhodes, Governor of the State of Ohio, participated in the cornerstone ceremony for the James A. Rhodes Hall-University Hospital. See page 600 for details. Photographs courtesy the Medical Illustrations Department, The Ohio State University College of Medicine.

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Malignant Manifestation of Benign Gastric and Duodenal Neoplasms

Richard H. Keys, Jr., M.D.
Richard E. Dean, M.D.

The clinical entity of benign tumors of the stomach and duodenum presenting as a cause of gastrointestinal symptomatology has been given limited consideration in the literature. Two cases, in addition to the clinical data of 11 other cases presenting as malignant manifestations of this particular lesion, are discussed. The surgical management in best handling this type of lesion is emphasized, as well as the symptomatology of the benign neoplasm, in an attempt to encourage the clinician to consider these lesions when ruling out pathology of the upper-gastrointestinal tract.

TRADITIONALLY, benign neoplasms of the stomach and duodenum have enjoyed little or no notoriety as clinical entities. The reasons for lack of concern about these tumors are multiple—they frequently are either incidental findings at autopsy or surgery; they seldom undergo malignant degeneration; and their malignant counterparts are assigned a high mortality rate when compared to most other malignancies.

Three of these “benign” gastric and duodenal lesions have manifested themselves recently as life-threatening problems. Two of them are presented briefly to illustrate the complications of hemorrhage and perforation. Following this, the clinical data of 11 additional cases of benign

neoplasms of the stomach and duodenum are presented. The discussion attempts to point out the specific aspects of these benign tumors which make them so apparent clinically.

Review of Patients' Records

A 45-year-old white man was admitted to the hospital on September 15, 1972 with a 30-hour history of melena. Physical examination revealed an acutely ill man in hypovolemic shock. Following 36 hours of conservative management, including 10 units of whole blood, the patient was taken to the operating room. At laparotomy, a well-encapsulated, firm mass measuring 2X2.5 cm was identified in the descending portion of the duodenum. This leiomyoma had a small, ulcerated, mucosal covering. Following surgical excision of this mass, the patient had an uneventful postoperative course and remains asymptomatic.

A 58-year-old white man was admitted to The Christ Hospital on September 9, 1972 with the chief complaint of epigastric pain going through to the back. An Hypaque upper gastrointestinal series obtained on September 13 revealed a perforated ulcer in the pyloric region of the stomach with a large filling defect immediately proximal. At laparotomy, a 7.0X4.0X2.5 cm well-encapsulated mass was identified on the posterior wall of the stomach with a large distal ulcer. The mass was identified as a benign, gastric lipoma. Following a 60-percent gastrectomy, vagotomy, and Billroth II operation, the patient had an uneventful recovery.

Clinical Data

Between 1965 and 1973, The Christ Hospital in Cincinnati had approximately 175,000 admissions. Of

Dr. Keys, Cincinnati, Chief Resident in Urology, University of Cincinnati Medical Center.

Dr. Dean, formerly Assistant Professor of Anatomy, University of Cincinnati College of Medicine, currently Associate Professor and Director of Surgery, Grand Rapids Campus, Michigan State University College of Human Medicine. Submitted February 9, 1976.

these admissions, a total of 14 patients were proved by microscopic examination of tissue to have benign tumors of the stomach and duodenum. Five of these tumors were incidental autopsy findings (Table 1). The remaining nine tumors were operatively excised due to their clinical appearance (Table 2). It is noteworthy that those tumors found at autopsy were all less than 1 cm in greatest dimension, whereas those tumors found clinically averaged 4 cm in dimension.

Discussion

Benign tumors of the stomach and duodenum are encountered relatively infrequently and, therefore, are not generally included in the differential diagnosis of upper gastrointestinal bleeding, obstruction, and other complications. However, because these tumors are very amenable to surgical correction, more consideration certainly should be given to them. There is a persistence in their appearance rate—one or two cases per year in most large hospitals.¹ Benign gastric tumors account for approximately 30 percent of all gastric lesions,² while as many as half of all duodenal tumors are benign.

When the size of those benign lesions that presented ante mortem is compared to those incidentally discovered at autopsy, it is obvious that the size of the tumor is closely associated with its ability to produce symptoms. In our series, all of the tumors found after death were less than 1 cm in greatest dimension, whereas eight of the nine symptom-producing tumors were greater than 1 cm in largest dimension, averaging 4 cm. Thus, the ability of these benign tumors to produce symptoms appears to be related to tumor size.

The clinical manifestations of benign tumors are as varied as those symptoms produced by their malignant counterparts. As demonstrated by the foregoing clinical records, they may present as life-threatening hemorrhage or perforation. They also commonly present as obstruction, weight loss, pain, and anemia. Other signs and symptoms include indigestion, weakness, and gastric intussusception.³

The second patient's record presented indicates a perforation of the gastric pylorus just distal to a large lipoma. Although the exact pathophysiology of ulceration and perforation secondary to a benign tumor is uncertain, it has been postulated that the local ulcerogenic effect of a benign tumor arises from local mucosal dysfunction caused by the mere presence of the tumor.¹ It is obvious that as the tumor increases in size, some degree of pressure necrosis must occur. Also, the vascular supply to tissues immediately adjacent to a large tumor will be diminished because of its longer route and compression to vessels. As many as one-third of benign duodenal tumors have been associated with distal obstruction.

The surgeon's approach to a gastric or duodenal tumor is influenced by impressions and information regarding the malignant potential of the lesion.⁴ These impressions, unfortunately, may be biased by the severity (or lack of severity) of the clinical problem. (A patient with a "benign" gastric tumor was discharged because

TABLE 1. Benign Gastric and Duodenal Tumors Found at Autopsy

Age (Years)	Sex	Size of Lesion (cm)	Location	Symptoms	Histologic Type
80	F	0.3X0.2	Stomach	None	Leiomyoma
68	F	0.6X0.6	Duodenum	None	Leiomyoma
66	M	0.2X0.3	Duodenum	None	Lipoma
82	F	0.5X0.4	Stomach	None	Adenomatous polyp
64	F	0.5X0.3	Stomach	None	Adenomatous polyp

of questionable cardiac status; he returned in eight months only to succumb to his gastric neoplasm.)

Ultimately, it is the surgeon who decides what course of action should be taken regarding these benign tumors. He may gather information from the radiologist, cytologist, and gastroscopist which may or not be helpful. Radiologically, only 60 percent of benign gastric tumors may be demonstrated and after radiologically illustrating the tumor, considerable questions as to its exact nature (benign, malignant, or ulceration) still may remain. Gastric cytology, in the best of hands,^{5,6} is only 80-percent accurate in reporting either suspicious or positive washings in patients later proved to have gastric carcinoma. Gastric tumors known to be benign may undergo malignant degeneration.⁷ Even if tissue from gastroscopic biopsy is available, it may be difficult to differentiate microscopically between benign smooth-muscle tumors and the so-called benign metastasizing leiomyoma of the stomach.⁸ Although benign tumors of the duodenum are more frequent than malignant tumors,⁹ cytology, radi-

TABLE 2. Benign Gastric and Duodenal Tumors Encountered Clinically

Age (Years)	Sex	Size of Lesion (cm)	Location	Symptoms	Histologic Type
74	M	4.0X3.0	Stomach	Full stomach	Leiomyoma
70	M	0.8X4.0	Duodenum	Obstruction	Lipoma
71	M	1.2X1.5	Duodenum	None*	Leiomyoma
47	M	0.8X1.0	Duodenum	Abdominal	Leiomyoma
69	M	6.0X2.0	Duodenum	Obstruction	Leiomyoma
89	F	3.0X3.0	Pylorus	Obstruction	Adenomatous polyp
45	M	2.5X2.0	Duodenum	Hemorrhage	Leiomyoma
47	M	3.8X3.5	Stomach	Hemorrhage	Leiomyoma
58	M	7.0X4.0	Stomach	Perforation	Lipoma

*Found at previous vascular abdominal surgery.

ology, and gastroscopy offer less in preoperative differentiation than they do with gastric tumors.

In short, the surgeon stands alone in determining the nature of the gastric or duodenal lesion. However, he may add to his decision-making tools the fact that a benign tumor of the stomach or duodenum may be as life-threatening as its malignant counterpart. Does this make the inappropriate, overused statement "when in doubt, cut it out" appropriate?

Summary and Conclusion

The records of 14 patients having benign gastric and duodenal ulcers have been reviewed. The clinical manifestation of these tumors correlated well with their size. All symptomatic benign tumors failed to improve with conservative management, but they responded well to surgical resection. Benign tumors of the stomach and duodenum should be considered more frequently as a cause of upper-gastrointestinal symptomatology, and prompt, aggressive, surgical therapy should be employed as soon as feasible.

References

1. McBrien MP, Jarrett PE: Leiomyosarcoma of the duodenum. *Brit J Surg* 58:685-689, 1971.
2. Baumann-Schenker von R: The diagnosis of duodenal tumors. *Radiol Clin North Am* 19:257-260, 1950.
3. Kay S: Smooth muscle tumors of the stomach. *Surg Gynecol Obstet* 119:842-846, 1964.
4. Hoffman DC, Goligher JC: Polyposis of the stomach and small intestine in association with familial polyposis coli. *Brit J Surg* 58:126-128, 1971.
5. Charles RN, Kelley ML, Competi F: Primary duodenal ulcers: a study of 31 cases. *Arch Intern Med* 111:23-33, 1963.
6. Foushee, JH, Kalnins ZA, Dixon FR, et al: Gastric cytology: evaluation of methods and results in 1,670 cases. *Acta Cytol* 13:399-406, 1969.
7. Beard RJ, Lee EC, Haysom AH, et al: Non-carcinomatous tumours of the stomach. *Brit J Surg* 55:535-538, 1968.
8. Benedict EB, Allen AW: Adenomatous polypi of the stomach with special reference to malignant degeneration. *Surg Gynecol Obstet* 58:79-84, 1934.
9. Ochsner SF, Janetos GP: Benign tumors of the stomach. *JAMA* 191:881-887, 1965.

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**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

The Content: Dominate
of Health Progress
RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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Aspirin* Hepatotoxicity in Adults with Rheumatoid Arthritis

John R. Wilson, M.D.

Aspirin-induced hepatitis is described in two adults with rheumatoid arthritis who were given 3.6 gm aspirin daily for less than two weeks. The hepatitis was reversed by discontinuing the aspirin therapy. The hepatotoxicity appeared to be primarily dose related since one of the patients subsequently took moderate amounts of aspirin for over one year with no evidence of hepatic damage.

CONTINUOUS HIGH-DOSE ASPIRIN therapy can cause hepatocellular damage in children with rheumatic fever or juvenile rheumatoid arthritis^{1,2} and in adults with systemic lupus erythematosus.^{3,4} However, except in a 1974 abstract by Seaman et al,⁵ aspirin-induced hepatotoxicity has not been reported in adults with rheumatoid arthritis. The clinical data for two such patients are described herein.

A 58-year-old black woman, diagnosed as having rheumatoid arthritis in 1961, was admitted to the hospital in August 1974 for control of her arthritis. Previously, her arthritis had been well controlled on aspirin therapy.

On admission, the patient had a nontender liver measuring 6 cm, subcutaneous nodules, and marked inflammation of multiple joints. The rheumatoid factor titer was 1:1280, antinuclear antibody titer 1:80, serum glutamic oxaloacetic transaminase (SGOT) level 19 mU/ml (normal 7-40 mU/ml), serum glutamic pyruvic transaminase (SGPT) 10 mU/ml (normal 7-40 mU/ml), serum bilirubin level 0.4 mg/100 ml, and serum alkaline phosphatase level 69 mU/ml (normal 30-125 mU/ml).

Aspirin therapy, 3.6 gm daily in six divided doses, was begun. Within two weeks, the transaminase levels

rose, reaching a peak of SGOT 263 mU/ml and SGPT 161 mU/ml (Fig. 1). After aspirin therapy was stopped, the transaminase levels rapidly returned to normal. Low-dose aspirin therapy was restarted following discharge from the hospital.

In July 1975, the patient was readmitted for mild congestive heart failure. The SGOT level was 53 mU/ml, SGPT 13 mU/ml, and serum alkaline phosphatase 193 mU/ml. Aspirin therapy, 3.6 gm daily, was instituted even though the patient's arthritis had been well controlled in the clinics on lower dosages. By the 12th hospital day, the SGOT level was 1,250 mU/ml, SGPT level 590 mU/ml, bilirubin 0.6 mg/100 ml, and salicylate level 30.1 mg/100 ml. The patient denied having nausea, bloating, or tinnitus. Aspirin therapy was again discontinued. One week later, the SGOT level had fallen to 37 mU/ml and the SGPT level to 55 mU/ml.

A 28-year-old black woman was admitted to the hospital in September 1975 for control of her rheumatoid arthritis. She had been on aspirin therapy with salicylate levels of 16-17 mg/100 ml ever since the appearance of rheumatoid arthritis two years previously.

On admission, she had a nontender liver and severe polyarthritis. The rheumatoid factor titer was 1:320, antinuclear antibody titer negative, SGOT level 19 mU/ml, SGPT level 30 mU/ml, bilirubin 0.3 mg/100 ml, and serum alkaline phosphatase 112 mU/ml. A salicylate level was 15.8 mg/100 ml.

Aspirin therapy, 3.6 gm daily in six divided doses, was begun. By the tenth hospital day, SGOT level was 350 mU/ml, SGPT level 229 mU/ml, and salicylate level 20 mg/100 ml (Fig. 2). Aspirin therapy was stopped. In 48 hours, the SGOT level had fallen to 78 mU/ml and

*Aspirin—chemical name: salicylic acid acetate. A compound, $C_9H_8O_4$, occurring as white crystals that are commonly tabular or needle-like, or as a white, crystalline powder; used as an analgesic, antipyretic, and antirheumatic. Called also acetylsalicylic acid (definition—*Dorland's Medical Dictionary*).

Dr. Wilson, Cleveland, Resident in Medicine, Cleveland Metropolitan General Hospital.

Reprint requests to Department of Medicine, Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland, Ohio 44109 (Dr. Wilson)

Submitted May 3, 1976.

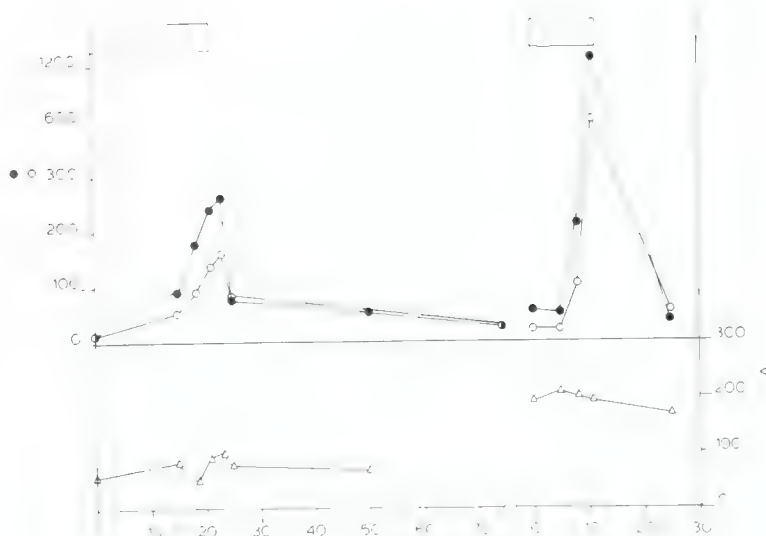


FIG. 1. Transaminase and alkaline phosphatase levels in first patient. (See text for normal laboratory values.)

the SGPT to 146 mU/ml. One week later, the transaminase levels were normal.

Discussion

Aspirin-induced hepatotoxicity is a problem likely to be encountered only in hospitalized patients. It usually is brought on by the daily ingestion of 3.6 gm or more of aspirin for one to two weeks, a situation unlikely to occur in most outpatients. The chemical picture is that of hepatocellular injury: serum alkaline phosphatase and bilirubin levels remain fairly normal while transaminase levels rise to 2 to 20 times normal. Clinical symptoms are rare. Liver biopsies taken from both adults and children with aspirin-induced hepatotoxicity have typically shown ballooning degeneration of liver cells with focal necrosis, inflammatory infiltration of portal tracts, and acidophilic-body formation.

The mechanism whereby aspirin damages the liver is unknown. The presence of underlying liver disease may play a significant part. Okumura et al challenged 20 patients with several types of liver disease with 2 gm of aspirin daily for three weeks and found that 11 had a significant rise in their transaminase levels.⁶ However, most evidence, such as the induction of hepatotoxicity in six of eight rabbits given sufficient aspirin to raise their salicylate levels over 30 mg/100 ml⁷ and the development of both the chemical and pathologic findings of aspirin-induced hepatotoxicity in an otherwise healthy nurse taking 9.0 gm of aspirin daily,⁸ suggests that aspirin does have a direct toxic effect on the normal liver.

The hepatotoxicity appears to be primarily dose related. However, the apparent rarity of the reaction and the more marked elevations in transaminase levels which commonly follow rechallenge with aspirin, suggest some type of hypersensitivity reaction. High levels of salicylates may lead to the production of an intermediate metabolite

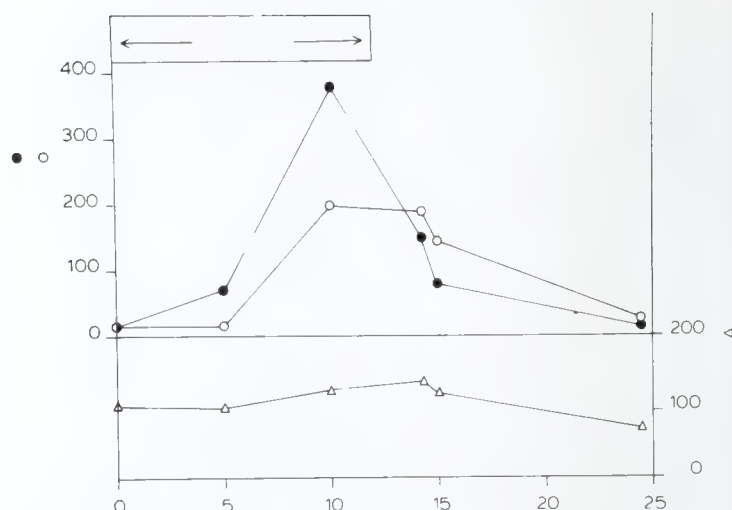


FIG. 2. Transaminase and alkaline phosphatase levels in second patient.

to which certain patients are hypersensitive. Under any circumstance, the fact remains that low dosages of aspirin do not seem to cause hepatotoxicity even in aspirin-sensitive patients. Therefore, those patients who develop aspirin-induced hepatitis as hospital inpatients probably can be safely restarted on moderate or low dosages of aspirin as outpatients.

Summary

Aspirin-induced hepatitis is described in two patients with rheumatoid arthritis who were given 3.6 gm of aspirin daily for less than two weeks. The hepatitis was reversed rapidly by discontinuing the aspirin therapy. The hepatotoxicity appeared to be primarily dose related since one of the patients subsequently took moderate amounts of aspirin for over one year with no evidence of hepatic damage.

References

1. Manso C, Taranta A, Nydick I: Effect of aspirin administration on serum glutamic oxaloacetic and glutamic pyruvic transaminases in children. *Proc Soc Exp Biol Med* 93: 84-88, 1956.
2. Russell AS, Sturge RA, Smith MA: Serum transaminases during salicylate therapy. *Br Med J* 2:428-429, 1971.
3. Seaman WE, Ishak KG, Plotz PH: Aspirin-induced hepatotoxicity in patients with systemic lupus erythematosus. *Ann Intern Med* 80:1-8, 1974.
4. Wolfe JD, Metzger AL, Goldstein RC: Aspirin hepatitis. *Ann Intern Med* 80:74-76, 1974.
5. Seaman WE, Plotz PH, Ishak KG: Aspirin-induced hepatotoxicity in patients with RA or systemic lupus erythematosus (SLE). *Arthritis Rheum* 17:325, 1974 (abstract).
6. Okumura H, Ichikawa T, Aramaki T, et al: Hepatic damage due to aspirin. *Naika* 17:749-755, 1966.
7. Janota I, Wincey CW, Sandiford M, et al: Effect of salicylate on the activity of plasma enzymes in the rabbit. *Nature (London)* 185:935-936, 1960.
8. Garber E, Craig RM, Bahu RJ: Aspirin hepatotoxicity. *Ann Intern Med* 82:592-593, 1975.

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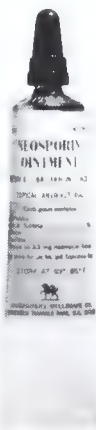
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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to



neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section)

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Maternal Health in Ohio

Maternal Mortality Report for Ohio — 1973*

By the OSMA Committee on Maternal and Neonatal Health

IN 1954, THE OHIO STATE Medical Association (OSMA) established a committee to survey and study, as a continuing research and educational program, the maternal mortality cases occurring each year in the State of Ohio.

Recently, the American Medical Association requested each state medical association to participate in a proposed regional program of "early planning for high-risk and newborn care." After an in-depth study of this proposal, the Council of the OSMA, in collaboration with the Committee on Maternal Health, has authorized this latter Committee to be renamed the "OSMA Committee on Maternal and Neonatal Health." The research and education program will be continued in each aspect of the newly named Committee. Physicians specializing in each phase of the study and survey will be included in the Committee's membership roll.

The research and educational program is now enriched by the transference of available statistics to a computer-oriented program, using terminology adapted from the International Classification.

It should be noted that the maternal mortality rate for 1973 is 1.3 per 10,000 live births, as compared to 1.41 per 10,000 live births in 1972.

Ohio Maternal Mortality Study Statistics for 1973

Total Live Births in Ohio, 1973	160,430
(Total cases in files, 19 years, 1955-1973=1,698)	
Total Cases Studied (1973)	34
Cases not studied due to lack of information ..	5
Undetermined	0
Maternal Deaths (Classified)	20
Nonwhite	7
White	13
Age:	
Teens	5
20s	9
30s	5
40s	1
Parity:	
Primigravidae	5
Multiparae	13
Unknown	2
Place of Death:	
Hospital	18
Home	2
Other	0
Type of Delivery:	
Not recorded	0
Operative	11
Nonoperative (spontaneous)	7
Not delivered	2
Route of Delivery:	
Not recorded	0
Vaginal	11
Cesarean	6
(antemortem)	6
(postmortem)	0
Laparotomy (ectopic preg.)	1
Not delivered	2

*Extracted from Report of the Committee on Maternal and Neonatal Health approved by the OSMA Council, July 1976.

Case Classification: (when death occurred)	
Not known	0
Group I (fr. concept. to 20th wk.)	1
Group II (fr. 20th wk. to 28th wk.)	0
Group III (fr. 28th wk. through term) ..	1
Group IV (postabortal, postpartum)	18
Autopsies	16
(Includes 6 coroners')	
Prenatal care (apparent from data sheets)	
None	0
Unknown or not reported	0
Adequate	11
Inadequate	3
Excluded (ectopic preg. and abortion) ..	6
Classification of preventability:	
Nonpreventable	6
Preventable (avoidable factor)	14
Patient responsibility (P ₁)	3
Personal responsibility (P ₂)	8
Both P ₁ and P ₂	3
P ₃	0
Classification of Primary Causes of Death:	
Hemorrhage	4
Abortion, without sepsis	0
Abruptio	0
Afibrinogenemia	0
Abruptio	0
Am. fl. embolus	0
Dead fetus	0
Ruptured uterus	0
Atony, uterine, postpartum	1
Ectopic pregnancy (without sepsis)	1
Laceration, extrauterine	0
Placenta praevia	0
Retained placenta	0
Ruptured uterus (no afibrin.)	2
Other	0

Infection	4
Abortion, alleged "criminal" (incurred) .	1
Abortion, septic, spontaneous	0
Up. resp. inf.	0
Other:	
Peritonitis	1
Septicemia (puerperal sepsis)	1
Septicemia (other)	1
Toxemia	4
Acute yellow atrophy	0
Hypertension, chronic (incl. hypertension with cerebrovascular hem.)	1
Eclampsia	3
Preeclampsia	0
Other	8
Amniotic fl. emb. (no hemorrhage)	1
Anesthesia	2
(general)	2
(regional)	0
Cardiac arrest (not specified)	0
Cardiac disease	0
Cerebrovascular hemorrhage (no tox.) ...	1
Chorioepithelioma	1
Diabetes	0
Hydatid mole	0
Lower nephron nephrosis	0
Pulmonary edema	0
Pulmonary embolus	3
Renal disease, chronic, unspecified	0
Shock, trauma (incl. acute puerperal inversion, uterus)	0
All other	0
High risk "OB" patients	2
(10 percent)	
High risk condition related to cause of death (10 percent)	2



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Simplified Intermaxillary Fixation

Robert H. Baxter, M.D.
James M. Lewis, M.D.
Subbarayuda Cuddapah, M.D.

The technique of application and postoperative management of achieving intermaxillary fixation is described with illustrations of the appliance used in this procedure.

THERE ARE NUMEROUS METHODS of achieving intermaxillary fixation. Each method has its own advantages and disadvantages. The method we describe is simple in its technique of application and operative management. The occlusion is easily maintained. However, this method is not advised for a complex fracture of the mandible and/or maxilla.

Materials and Methods

The appliance resembles a clam shell and is made of thin aluminum. There are two holes for passage of a wire on one half of the appliance. A #26G stainless steel wire is passed around the tooth near the gum, and the two ends of wire are passed into the two holes of the appliances (Fig. 1). The wire is tightened snugly by twisting it. Both halves of the appliance then are squeezed together, enclosing the twisted wire. Usually, four of these clam-shell appliances are applied on each side—two over the mandibular and two over the maxillary teeth (Fig. 2). Rubber bands may be applied vertically, or in a criss-cross manner, or both. In uncomplicated cases with mini-



FIG. 1. Metal appliances illustrated on skeletal model.

mal occlusal problems, the intermaxillary immobilization can be maintained effectively.

Indications

1. Unilateral condylar fractures of the mandible:
 - A. In older children and adults, we use this appliance with good intermaxillary fixation.
 - B. We do not recommend its use in most bilateral fractures of the mandible.
2. Nondisplaced fractures of the mandible.
3. Hairline fractures of the mandible where the pa-

(continued on page 584)

Dr. Baxter, Akron, Senior Staff, Akron Children's, Akron City, Akron General, St. Thomas, and Barberton Citizens Hospitals.

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Dr. Cuddapah, Youngstown, Staff, St. Elizabeth's Hospital.
Submitted January 12, 1976.

Simplified Intermaxillary Fixation

(continued from page 583)

tient's reliability concerning dietary restrictions and periodic follow-up is questionable.

4. Obesity:

At the present time, more and more people with compulsive eating tendencies are requesting intermaxillary wiring. We have found this to be a simple and successful method that can be performed as an office procedure.

5. Soft tissue surgery:

In those cases of reconstructive surgery around the oral cavity where intermaxillary fixation is indicated, the method promotes good healing and decreases post operative complications.

Advantages

1. Simplicity of application.
2. There is no cumbersome feeling of arch bars in the buccal cavity.
3. As the twisted wire is enclosed inside the two flanges, there are no problems and no complaints of sharp wire ends pricking the mucosa.
4. Patients can use a soft, baby toothbrush without damaging the intraoral appliance.

Discussion

Various technical devices are available to achieve intermaxillary fixation. We used a different and yet simple

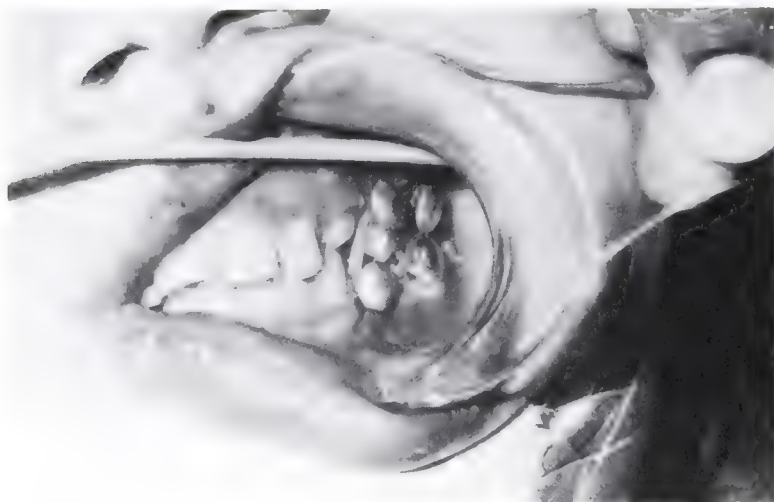


FIG. 2. Appliances illustrated in fixation of unilateral condyle of mandible fracture.

type which is more convenient and is well tolerated by the patients. However, this method is not a replacement for traditional methods when they are indicated.

Summary

A new and simple method of intermaxillary fixation has been presented with technical details, indications, and advantages of this procedure.

Librax® Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

*

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



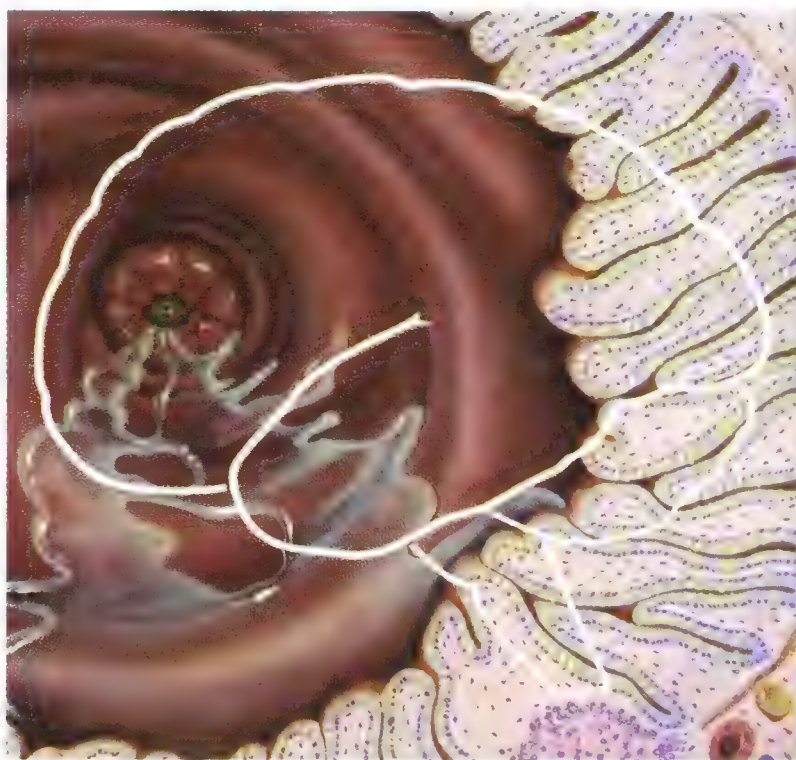
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The Role of Hypnosis in Today's Medicine

Bernard A. Safer, M.D.

A discussion of some of the conditions for which hypnosis can be used effectively, a description of the treatment, and the advantages of this therapy are presented.

HYPNOSIS HAS BEEN USED to stop smoking; to overcome obesity, alcoholism, and drug addiction; for tics, phobias, personality problems, loss of memory; to correct bad study habits and to improve athletic abilities. It also serves to relieve intractable pain; to overcome the fear and pain of dentistry; and to treat impotence, frigidity, infertility, dysmenorrhea, menopausal symptoms, and premenstrual tension. It is used effectively in the treatment of enuresis, insomnia, hypertension, migraine, peptic ulcer, and ulcerative colitis. Additional conditions that have been treated by hypnosis are: asthma, dermatologic problems, hemophilia, speech disorders, nail-biting, thumb-sucking, anorexia, and stage fright. Mental disorders can be managed rapidly by hypnoanalysis. Hypnosis can be used in obstetrics for deliveries and hyperemesis gravidarum, and in surgery for anesthesia, preoperative sedation, hiccoughs, and posthypnotic suggestions in the recovery room (for postoperative well-being).

All of these conditions usually are treated by hypnosis only after all medical and psychologic treatment has proved unsuccessful.

Patients and Methods

Many questions are asked about hypnosis, and these mostly concern misconceptions. Can anybody be hypnotized? The answer is "yes," with the following exceptions. Very young or very old patients cannot be hypnotized because they do not concentrate well. Also, hypnosis cannot be used with mentally upset or mentally deficient patients or with those who simply don't want to experience the hypnotic state.

Since most medical schools do not include hypnosis in their curriculum, most physicians are completely unfamiliar with it. Hypnosis is merely a state of complete muscular relaxation where the conscious mind goes to

sleep and the subconscious takes charge. In this state, the patient will accept suggestions for solving the problems that plague him. (The conscious mind will not help because it feels that it already has enough duties to perform.)

Consider the situation of a patient in whom every medical modality has been employed. Consultants and psychiatrists also are engaged, but nothing helps. The patient then is advised to go home and live with his problem—some can but most cannot. It is in such instances that hypnosis can fill the gap. It assures the patient that there is still hope for a solution of his problems. Hypnosis never was meant to replace medical therapy, only to augment it when all other modalities have been unsuccessful.

A patient in hypnosis is not asleep, in a trance, or unconscious. There is no difficulty in awakening, no secrets are disclosed, and patients do not lose their will power. They simply are relaxed. They can hear, feel, see, and think, and they are completely aware of what is taking place. No one can be hypnotized against his will or be unaware of it happening. People actually hypnotize themselves; the physician only guides them. There is absolutely nothing dangerous about hypnosis. The patient does not have to accept any suggestions. It is a pleasant experience, and many fringe benefits are afforded from the relaxation alone. Hypnosis can accomplish anything that is claimed for acupuncture and accomplish it better, with no dangers or complications.

Sessions in hypnosis are given once a week and last from one to two hours, depending on the needs of the patient. Autohypnosis is taught so that reinforcing suggestions can be given at home. This shortens the length of therapy, saves additional expense, and teaches a procedure which is of inestimable value. Most conditions treated by hypnosis can be corrected in 6 to 12 sessions.

The attitude and cooperation of the patient greatly influence the course of the therapy. Those who practice faithfully at home and keep regular appointments with their therapist obtain the best and quickest results.

Comment

There is nothing magic about hypnotic therapy, nor is it the answer to all man's ailments and problems. It is only an additional weapon in the struggle against illness, and should take its place beside other well-established therapeutic modalities.

Dr. Safer, Cincinnati, Staff Member, Children's, Jewish, and Providence Hospitals.
Submitted January 21, 1976.



Tough...

(even when
pain calls
for codeine)

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Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that acetaminophen and codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.



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Codeine Phosphate, USP-30 mg
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to complement codeine with little risk of APC complications

*Mielke, C.H., et al.: JAMA
235:613 (Feb. 9) 1976.

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obituaries

JOHN M. CAVANAUGH, M.D., Canfield; Loyola University Stritch College of Medicine, Maywood, Illinois, 1925; age 80; died July 20; member OSMA and AMA.

CARL T. DOEING, M.D., Albuquerque, New Mexico; Loyola University Stritch College of Medicine, Maywood, Illinois, 1938; age 70; died August 3; member OSMA and AMA.

JOHN J. HARRISON, M.D., Napoleon; University of Michigan Medical School, Ann Arbor, 1931; age 73; died July 28; member OSMA and AMA.

LERLEEN C. HATCH, M.D., Scottsdale, Arizona; Jefferson Medical College, Thomas Jefferson University, Philadelphia, 1928; age 78; died October 20, 1975; member AMA.

CHARLES W. HUNSCH, M.D., Cincinnati; University of Cincinnati College of Medicine, 1934; age 72; died August 3; member OSMA and AMA.

ALEXANDER MARCUS, M.D., Cleveland; Case Western Reserve University School of Medicine, 1922; age 78; died July 23; member OSMA and AMA.

ALBERT W. McCALLY, M.D., Dayton; Case Western Reserve University School of Medicine, 1917; age 84; died August 3; member OSMA and AMA.

FRANZ MIKETTA, M.D., Cincinnati; Miami Medical College, Cincinnati, 1907; age 94; died August 2.

GUSTAVO J. PERAZA, M.D., Mentor; College of Medicine de la University La Habana, Cuba, 1955; age 48; died July 29; member OSMA and AMA.

ERNEST H. PLANCK, M.D., Daphne, Alabama; Tulane University School of Medicine, New Orleans, 1937; age 66; died July 7; member OSMA and AMA.

ALBERT F. SARVER, M.D., Greenville; Ohio State University College of Medicine, 1912; age 88; died August 2; member OSMA and AMA.

JOHN D. SKOW, M.D., Toledo; Rush Medical College, Chicago, 1928; age 78; died August 9; member OSMA and AMA.

BURON C. STUHLMAN, M.D., Dayton; University of Cincinnati College of Medicine, 1937; age 64; died July 23; member OSMA and AMA.

FOSTER M. WILLIAMS, M.D., Cincinnati; University of Cincinnati College of Medicine, 1930; age 71; died July 28; member OSMA and AMA.

If your angina patient* isn't having 3 out of 4 better days than usual... try Cardilate[®] (ERYTHRITYL TETRANITRATE)

*Please note: unstable angina patients may be refractory to all long-acting nitrates

INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

SUPPLIED: 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

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1. Russek HI: AM J M Sc 239:478, 1960



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COLLEAGUES IN THE NEWS

E. THOMAS BOLES, JR., M.D., Columbus, has been elected President-Elect of the American Pediatric Surgical Association. Dr. Boles is Chief of Pediatric Surgery at Children's Hospital and Professor of Surgery at The Ohio State University College of Medicine. Included among his professional affiliations are the American College of Surgeons, the American Academy of Pediatrics, and the AMA.

PAUL D. BUNN, M.D., has been appointed Head of the Endocrinology Service and Associate Program Director for the Medical Residency Program at the Youngstown Hospital Association. In addition, he will be Clinical Curriculum Coordinator for the Internal Medicine Council of the Northeastern Ohio Universities College of Medicine. Prior to his appointment, Dr. Bunn served as Assistant Professor of Medicine and Co-director of the Phase III Curriculum at The Ohio State University College of Medicine. He is a member of the Medical Society of the State University Hospitals and the Central Ohio Diabetes Association.

RICHARD BURK, M.D., Dayton, is a new member of the State of Ohio Rehabilitation Services Commission. Dr. Burk chairs the Department of Physical Medicine and is Professor in the School of Medicine at St. Elizabeth Medical Center in Dayton. He also directs the rehabilitation evaluation and medical service unit at the center. Prior to joining the St. Elizabeth Staff, Dr. Burk was Dean of the School of Allied Health Professions at the University of Texas Medical School, Dallas, and Professor and Director of Rehabilitation Services at The Ohio State University College of Medicine.

S. A. BURROUGHS, M.D., Ashtabula, has been elected to membership in the American Urological Association. Dr. Burroughs, an Ashtabula native, has been practicing in the community since 1940.

LARRY C. CAREY, M.D., Columbus, has begun a three-year term as Secretary of the Society for Surgery of the Alimentary Tract. In addition, he has been appointed to a six-year term on the Board of Directors of the American Board of Surgery. Dr. Carey is Professor and Chairman of the Department of Surgery of The Ohio State University College of Medicine.

HERBERT DERMAN, M.D., Columbus, has been appointed Director of Laboratories at Riverside Methodist Hospital. Dr. Derman has served as Chief of Path-

ology at Kingston (New York) Hospital and Director of the City of Kingston Laboratory since 1950.

MICHEL G. FARAH, M.D., Cleveland; **JOHN D. KRAMER, M.D.**, Akron; **CHARLES J. McGAFF, M.D.**, Toledo; and **ELAINE Y. ROSIN, M.D.**, Cincinnati, have been granted Fellowship in the American College of Cardiology.

PAUL F. FLETCHER, M.D., Chillicothe, has assumed duties as Chief of Staff at the Chillicothe Veterans Administration Hospital. A graduate of Meharry Medical College, Dr. Fletcher has served as staff psychiatrist at the VA Hospital in Togus, Maine, and as assistant superintendent at the Taunton State Hospital in Taunton, Massachusetts.

LEONARD GOLDBERG, M.D., Cleveland Heights, received the 12th Annual Julius E. Goodman Award from Mt. Sinai Hospital. This award recognizes distinguished service. Dr. Goldberg, on the hospital staff since 1949, is an associate in medicine and head of the electrocardiography section. He has been on the faculty of the Case Western Reserve University School of Medicine since 1951.

LOUIS J. R. GOOREY, M.D., Columbus, has been elected President of the Board of Directors of the Central Ohio Lung Association. In addition, Dr. Goorey will continue to serve as Representative Director to the Ohio Lung Association and as a member of the Medical Advisory Committee.

BRUCE D. GRAHAM, M.D., Columbus, has been named Ambulatory Medical Director at Children's Hospital. Professor of Pediatrics at The Ohio State University College of Medicine, Dr. Graham will have medical responsibility for the hospital's 44 outpatient clinics, the emergency room, and the five community clinics located in the inner-city area. Dr. Graham is District V Chairman of the American Academy of Pediatrics and the Academy's representative to the AMA's National Joint Practice Commission. He is also a member of the Board of Trustees of the Mid-Ohio Health Planning Federation, the Board of Directors of the Federation's Franklin County Health Planning Council, and the Medical Advisory Board of the State Crippled Children's Services.

JERRY GUY, M.D., Columbus, has been appointed Coordinator of Education-Medicine at Grant Hospital. Dr. Guy will coordinate the teaching service among all Grant Hospital residents as well as perform other duties normally associated with the position of director of medical education.

GEORGE W. HAMBRICK, JR., M.D., Cincinnati, has been appointed Professor and Director of the Department of Dermatology at the University of Cincinnati College of Medicine. The first full-time director, Dr.

Hambrick has been serving as Professor of Dermatology at The Johns Hopkins School of Medicine and Director of the Subdepartment of Dermatology at The Johns Hopkins Hospital. His professional activities include being past-president of the Society for Investigative Dermatology, Inc., the Philadelphia Dermatological Society, and the Dermatology Foundation. Dr. Hambrick, a Fellow of the American College of Physicians, has made research contributions in the areas of experimental acne, infectious diseases, and birth defects.

Dr. Hambrick succeeds **LEON GOLDMAN, M.D.**, Professor of Dermatology and part-time department director for 29 years.

The Mahoning Valley Community Blood Center has on its Board of Trustees a number of Youngstown Hospital Association physicians. Serving on the Board are **JAMES R. HILL, M.D.**, pathologist and Vice Chief of the Division of Pathology; **LAWRENCE M. PASS, M.D.**, Director of Clinical Hematology Service; **ARTHUR E. RAPPOPORT, M.D.**, pathologist and Chief of the Division of Pathology; and **ROBERT A. WILTSIE, M.D.**, Medical Director.

Appointment of new members of the faculty for the basic medical sciences program of Northeastern Ohio Universities College of Medicine has been announced by Robert A. Liebelt, M.D., Dean. **FERENC HUTTERER, M.D.**, formerly Professor of Pathology at Mount Sinai School of Medicine, New York, has been appointed Professor and Program Chief of Molecular Pathology and Biology. **C. WILLIAM KECK, M.D., M.P.H.**, Director of the Department of Public Health for the City of Akron, has been appointed Associate Professor of Community Medicine.

STANLEY JAFFEE, M.D., Cleveland, Head of the Division of Plastic Surgery at Huron Road Hospital, has been promoted to Associate Clinical Professor of Plastic Surgery at Case Western Reserve Hospitals. Dr. Jaffee was also recently elected Vice President of the Ohio Valley Plastic Surgery Society.

RICHARD P. LEWIS, M.D., Columbus, has been elected Governor for Ohio for the American College of Physicians. Dr. Lewis, Director of the Division of Cardiology at The Ohio State University Hospitals, will be responsible for the annual regional meeting as well as chairing the committee to select members at the local level and make recommendations for fellowship.

JOHN N. McCANN, M.D., Youngstown, was awarded the honorary degree of doctor of medical arts from Youngstown State University. Dr. McCann, a general practitioner in Youngstown for over 45 years, was the first Chairman of the Board of Trustees of the University as a state institution. He has held the presidency of the Ohio Board of Medical Examiners, the Federation of State Medical Boards, and the Mahoning County Medical Society.

CHARLES H. McGOWEN, M.D., Clinical Staff member of the Division of Medicine and Endocrinology Service at The Youngstown Hospital Association, has published a book entitled *In Six Days*. This book is a treatise on creation written to give the lay reader insight into scientific support for the teachings of the *Bible*. Dr. McGowen, a graduate of The Ohio State University College of Medicine, is certified by the American Board of Internal Medicine.

ORLANDO J. MARTELO, M.D., Cincinnati, has joined the University of Cincinnati College of Medicine faculty as Professor of Medicine. Dr. Martelo will direct the Division of Hematology-Oncology of the Department of Internal Medicine which will emphasize management of patients with neoplastic diseases as well as conduct research in related areas. Prior to this appointment, Dr. Martelo was Associate Professor at the University of Miami (Florida) School of Medicine and Visiting Scientist in the Department of Biochemistry at the University of Washington, Seattle. Dr. Martelo is certified by the American Board of Internal Medicine in internal medicine and hematology. In addition, he is a member of the American Society of Hematology and the American Federation for Clinical Research and is a Fellow of the American College of Physicians.

WILLIAM A. MILLHON, M.D., Columbus, has been reelected to the Board of Trustees of the American Society of Internal Medicine.

RICHARD D. MURRAY, M.D., Youngstown plastic surgeon, will be invested as a member of the Knights of Malta under the Russian Priory of the Order of St. John of Jerusalem, Knights Hospitalers. The honor comes to him for deciphering and translating the Prophecies of Nostradamus as they apply to Russia. Dr. Murray's latest book, *The Key to Nostradamus*, interprets the quatrains of the 16th century mystic and seer.

STANLEY W. OLSON, M.D., Provost of the Northeastern Ohio Universities College of Medicine, was the main speaker at the Youngstown State University summer commencement. Dr. Olson, former President of the Southwest Foundation for Research and Education, has served as Dean and Professor of Medicine, University of Illinois College of Medicine; and Dean and Professor of Medicine, Baylor University College of Medicine.

ERWIN RABIN, M.D., Cleveland, has been appointed Director of the Department of Pathology at Huron Road Hospital. Prior to this appointment, Dr. Rabin served as Chairman of the Department of Pathology at Stormont-Vail Hospital in Topeka, Kansas. He was also pathologist of the Lattimore-Fink Laboratories, Associate Professor of Pathology at Washington University School of Medicine, and Adjunct Associate Professor of Pathology at the University of Kansas Medical Center.

(continued on page 596)

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TABLETS, 20 mg.

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Notice to All OSMA Members

Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA*, will expire on December 31, 1976. Here's how to renew:

Mail your dues now to the SECRETARY-TREASURER OF YOUR COUNTY MEDICAL SOCIETY or to the OSMA if your County Society has asked OSMA to direct bill for all three levels of dues on behalf of the Society.

OSMA dues are \$125.00. AMA membership dues are \$250.00. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee-American Medical Political Action Committee (OMPAC-AMPAC) dues are \$35. OMPAC-AMPAC membership is recommended.

Life Active Membership— a category of membership approved by the 1973 OSMA House of Delegates. This membership is available to 500 physicians who make a single, lifetime dues payment of \$1,250.

Student Membership— a category of membership for full-time students enrolled in medical schools approved by the AMA.

Many members will want to send one check to cover local, state, national, and OMPAC-AMPAC dues. Your local Secretary-Treasurer will forward your state and national dues to the OSMA Columbus Office. That office will certify AMA dues. OMPAC-AMPAC dues will be forwarded to OMPAC Headquarters.

As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal* and copies of the *OSMAgram* and *Your Doctor Reports*, without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA* and the *American Medical News*.

The member who becomes eligible for exemption from dues and wishes to take advantage of exemption, should notify the Secretary-Treasurer of his County Medical Society. After exemption has been established, it is automatically renewed annually, unless the status changes.

COLLEAGUES IN THE NEWS

M. D. RAM, M.D., Director of the Department of Surgery at Huron Road Hospital, Cleveland, has been appointed to the Board of Directors of the American College of Surgeons, Ohio Chapter. He will serve as Chairman of the Special Projects Committee.

The Ohio Academy of Family Physicians has installed its officers for the 1976-1977 term. Physicians holding office in the society include: **H. JUDSON REAMY, M.D.**, Dover, president and national delegate; **KENNETH FREDERICK, M.D.**, Cincinnati, president-elect; **TENNYSON WILLIAMS, M.D.**, Columbus, vice president; **OLIVER K. ROTH, M.D.**, Cincinnati, treasurer; **ANDREAS S. AHBEL, M.D.**, Canton, speaker of the house of delegates; **DANIEL R. SULLIVAN, M.D.**, Maumee, vice speaker; **DAVID A. BARR, M.D.**, Lima, and **CARL E. SPRAGG, M.D.**, New Concord, national alternates.

Directors are **DOUGLAS P. LONGNECKER, M.D.**, Dayton; **ARMIN FUHLBRIGGE, M.D.**, Toledo; **JANIS LAUVA, M.D.**, Wellsville; **ROBERT JOHNSON, M.D.**, Coshocton; **JOHN E. VERHOFF, M.D.**, Columbus; and **EUNICE R. CARTER, M.D.**, Cuyahoga Falls.

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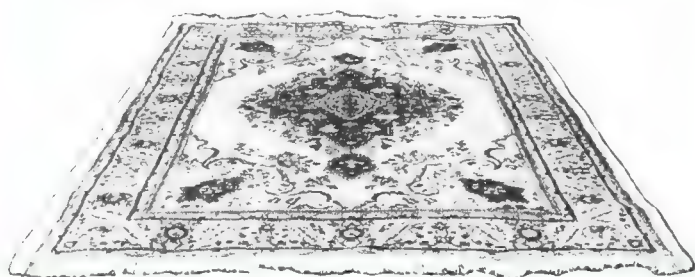
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DOYT E. FARLING, M.D., Payne, was selected Family Physician of the Year at the Society's Annual Meeting. In addition to his practice, Dr. Farling serves as Paulding County Coroner.

HERBERT W. RIEMENSCHNEIDER, M.D., Columbus, was honored with "The Kidney Award" by the Kidney Foundation of Central Ohio for his dedication to kidney patients. Dr. Riemenschneider is Chairman of the Medical Advisory Board of the Foundation.

WILLIAM ROCHE, M.D., was honored by Gnadenhutten for 50 years of service to the community. The Twin City Hospital staff presented Dr. Roche a watch, and the village gave him a plaque to commemorate the occasion.

PENN G. SKILLERN, M.D., Cleveland, has been selected to serve on the committee which will help guide and review the work of the new Center for Research in Ambulatory Health Care Administration project. Dr. Skillern, along with 11 other representatives of several nationwide health organizations, will serve on the newly appointed steering committee for the project, Alternatives for Continuing Education in Group Practice Administration. Dr. Skillern is a member of the Cleveland Clinic Foundation.

TRENT SMITH, M.D., Columbus, has been promoted to Clinical Professor in the Department of Otorhinolaryngology of The Ohio State University College of Medicine.

JAMES STEPHENS, M.D., and his wife, **JEANNE STEPHENS, M.D.**, have been honored by the members of the Allen Memorial Hospital Association, Inc. The Stephens, who have practiced in Oberlin since 1942, will soon leave for Kenya, Africa, where they will provide medical care for the people of the area.

Two Columbus physicians have been elected officers of the Central Ohio Radiological Society. **ALFRED E. STOCKUM, M.D.**, will serve as president, and **DAN E. LEWIS, M.D.**, will be president-elect.

CHARLES WALTNER, M.D., Superintendent at Woodside Receiving Hospital at Youngstown for the past 18 years, has retired. Dr. Waltner joined the staff of the hospital in 1941 and practiced there until 1951, when he became Clinical Director and Assistant Superintendent at Cleveland State Hospital. While in Cleveland, Dr. Waltner served on the faculty of the College of Medicine, Department of Psychiatry of Western Reserve University. He is a Diplomate of the American Board of Psychiatry and Neurology.

WILBURN WEDDINGTON, M.D., Columbus, is the Vice Chairman of the Family Practice Section of the National Medical Association.

Cancer Management for the Practicing Physician

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Case Western Reserve University School of Medicine
Cancer Center of Northeast Ohio
Ohio Division of the American Cancer Society

November 4, 5, & 6, 1976

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Fees: Physicians in practice \$175
Physicians in training \$ 75
Nurses \$ 75

The program has been approved for **16 1/4 hours of Category I** continuing medical education credit by the AMA and 16 1/4 prescribed-elective hours by the American Academy of Family Physicians.

COURSE DESCRIPTION

The course will serve to acquaint the practicing physician with new aspects of therapy. The use of radiation therapy, chemotherapy, and immunotherapy and other modalities in cancer treatment will be stressed. Controversial areas of patient management, such as breast carcinoma, head and neck tumors, skin cancer, and gastrointestinal malignancies will be emphasized. Pediatric oncology and advances in gynecological and genitourinary tumor therapy will be covered. A survey of new diagnostic techniques such as body scanning and endoscopy will be presented. Control of the problems of infection, hypercalcemia, and pathological fractures will be discussed. The role of the family physician in the rehabilitation of the patient, and discussion of the psychological problems attendant in cancer therapy for both the patient and family will be covered.

The faculty will consist of visiting professors and members of the Case Western Reserve University School of Medicine.

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Please include all fees in one check. Make checks payable to: "Cancer Management for the Practicing Physician"

My wife will _____ will not _____ attend the wives program.

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Zip _____

National Cancer Institute Releases Mammography Guidelines

Interim guidelines on the use of mammography were released August 26 by the National Cancer Institute (NCI). The guidelines state that women under 50 years of age should not be subjected to the x-ray breast examination in routine screening procedures. The guidelines are based on the findings of a joint study conducted by the NCI and the American Cancer Society. The guidelines recommend continued use of mammography for women over 50 years of age and also for younger women whose family histories seem to put them in a high-risk group or who have symptoms suggestive of cancer.

AMA Operating Under Budget

AMA operating expenditures for the period December 1, 1975 through June 30, 1976 were \$3.5 million under budget, due to management controls established during the financial crisis of 1975. When financial reports showed that continuing controls were holding operating expenses under budget, the AMA allocated \$800,000 for new and

expanded programs. Funding for many programs had been held up pending reports on membership and on the effectiveness of the fiscal controls. Actual AMA expenses for the period December 1-June 30 were \$22.6 million, compared to budgeted expenses of \$26.1 million. AMA staff totaled 809 on June 30, 122 fewer people than the budget calls for.

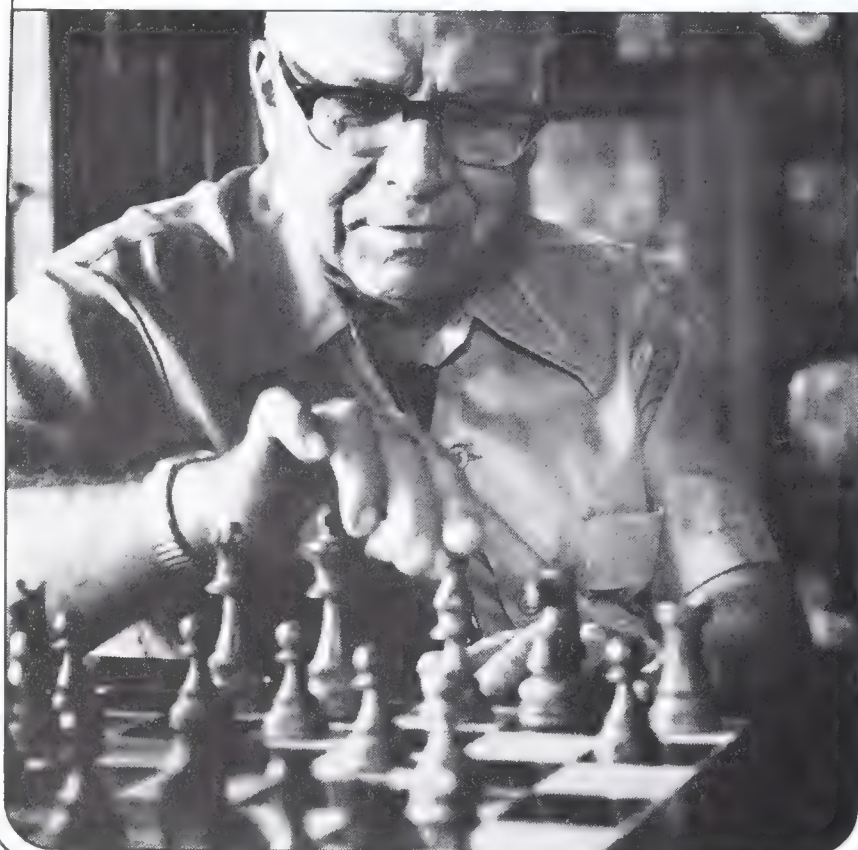
Cancer-Causing Potential of Chemicals Studied by Battelle

The cancer-causing potential of various chemical substances is being investigated by researchers at Battelle's Columbus Laboratories, Columbus, Ohio. The \$1.4 million study, scheduled for completion early in 1980, is being conducted under subcontract with Tracor Jitco, Inc., Rockville, Maryland, prime contractor for the National Cancer Institute's (NCI) Carcinogenesis Bioassay Program.

The Battelle study is part of an overall NCI Bioassay Program designed to identify a wide variety of potential cancer-causing compounds such as industrial chemicals, pesticides, food additives, and naturally occurring sub-

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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
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RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
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stances in the environment. The carcinogenicity, or cancer-causing potential, of these chemicals is determined by long-term experiments on laboratory animals.

The effects of such chemicals on laboratory animals have long-range importance for humans, but immediate direct correlations to human risk are difficult to determine. This is because factors such as metabolism, genetic susceptibilities, and immune responses— all of which can differ from one species to another and even between sexes— affect the cancer-causing potential of chemicals.

OSU Grads Choose Primary Care

Three of every four 1976 graduates of The Ohio State University College of Medicine are entering primary care residencies. According to the American Board of Medical Specialties, primary care includes family practice, internal medicine, pediatrics, and obstetrics and gynecology.

J. Hutchison Williams, M.D., Associate Dean of The Ohio State University College of Medicine, traces some of the resurging interest in primary care among Ohio State's medical students to social consciousness and the establishment of a Department of Family Practice within the college last year.

Forty-five of Ohio State's 1976 graduates chose family practice residencies. Eighteen of the residencies are in Columbus, four in Youngstown, three in Dayton, two in Canton, and one each in Akron and Toledo.

The AMA Council on Medical Education reported to the House of Delegates at the Annual Convention that approximately 60 percent of new medical graduates chose primary care specialties in this year's matching program. In 1973, the House established the policy that at least 50 percent of the graduates should enter residency training in primary care specialties. The AMA has also encouraged the development of family medicine residency programs, the Council reported; and 270 programs have been established since 1970. As of July 1, 1975, 3,270 residents were in family medicine.

Watch Mailing Costs

By now, the fact that a first-class letter costs 13 cents for the first ounce should be common knowledge. But, are all office staff aware that every additional ounce costs 11 cents? The rule of thumb should be: First-class mail is 11 cents per ounce plus two cents per piece for the Post Office.

(continued on page 603)

**COLD FEET
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Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
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AVAILABLE: Bottles of 100, 500, 1000.

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AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPONICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

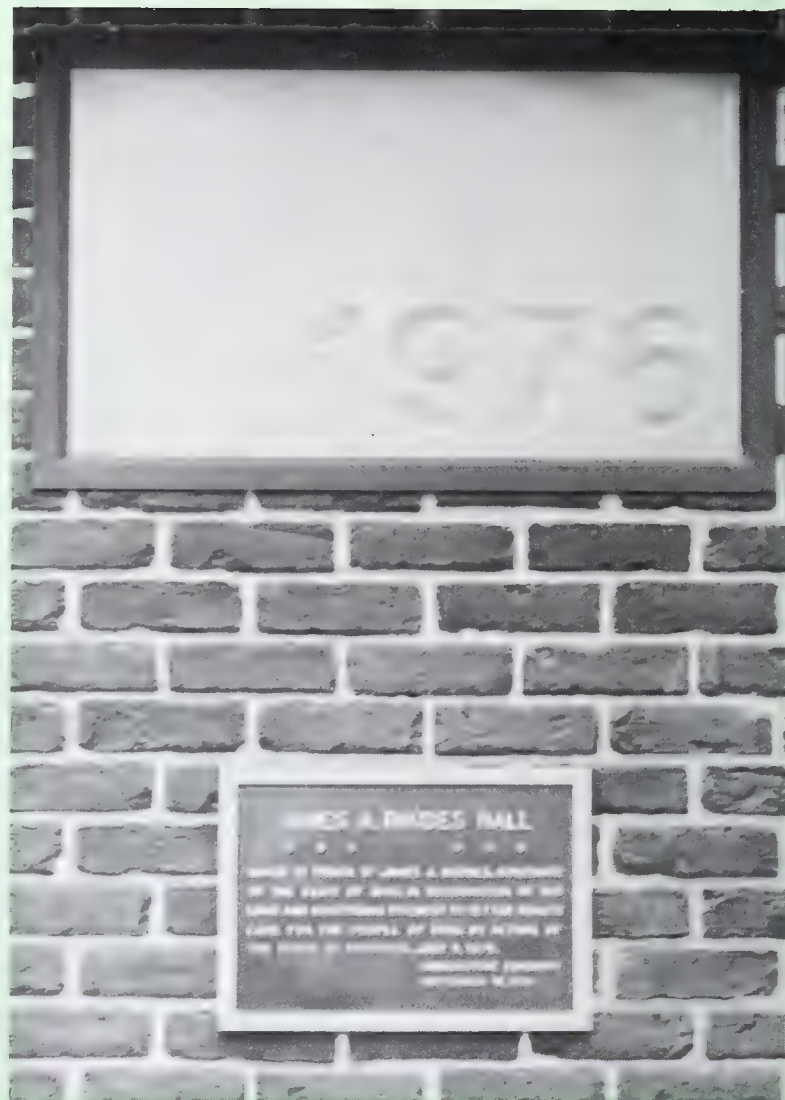
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OSU College of Medicine Dedicates James A. Rhodes Hall

During September, The Ohio State University held a cornerstone ceremony marking the dedication of the James A. Rhodes Hall— University Hospital. The Ohio State University Board of Trustees had previously voted unanimously to name the new facility after the Governor in recognition of his long-standing concern for maintaining excellence in all aspects of the Medical Center. The Governor, working with the leadership of the Ohio General Assembly, enabled the University to secure funds for the final \$28 million of the \$40.8 million facility.

The building will serve as a reminder of the dedication of both the Governor and the members of the Ohio General Assembly in providing the very best in medical education and public service for the people of Ohio



Secretary F. David Mathews

The featured speaker at the dedication was the Honorable F. David Mathews, Secretary of Health, Education, and Welfare (HEW). Secretary Mathews commended the facility and noted that it represented a partnership between the State of Ohio and HEW. In addition, he commented on the necessity of keeping ideals from being corrupted through mismanagement. He stated the problem is that pressures are forcing educators to become bureaucrats, thus short-changing both the educational system and the society that looks to it.

The James A. Rhodes Hall— University Hospital, when completed, will be a 12-story addition to the existing hospital. It will include new facilities for an Emergency Department, a Pharmacy Department, clinical classrooms, a radiology area, laboratories, and other ancillary support services. In addition, there will be a five-story, 362-bed area for the care of acutely-ill patients.

Other outstanding features of the new hospital facility include nine operating rooms, a 30-bed recovery unit with special support services, eight diagnostic x-ray rooms, and a closed-cart monorail system, allowing for an automated material handling system throughout the hospital.

The new structure is the capstone of a ten-year, \$100 million expansion building program, including nearly \$65 million in state funds, \$30 million in federal funds, and \$5 million in University funds.

During the ten-year expansion program, the entering class of medical students at The Ohio State University College of Medicine has grown from 150 students in 1965 to 233 students in 1976. This represents an increase of 55 percent. Completion of the new hospital complex will allow the number of entering medical students to increase to 264, a jump of another 25 percent.

(continued on page 602)



Left to right: Henry G. Cramblett, M.D., Dean, College of Medicine, and Acting Vice-President for Medical Affairs, The Ohio State University; Dr. Harold L. Enarson, President, The Ohio State University; The Honorable F. David Mathews, Secretary of Health, Education, and Welfare; The Honorable James A. Rhodes, Governor of the State of Ohio; and Mr. M. Merle Harrod, Chairman, Board of Trustees, The Ohio State University.

Henry G. Cramblett, M.D., Dean,
The Ohio State University College of Medicine
Remarks Upon Laying the Cornerstone

Governor Rhodes, Secretary Mathews, distinguished members of the platform group, honored alumni, distinguished guests, and friends of The Ohio State University, we welcome each of you here today for what is truly an important occasion in the history of The Ohio State University Medical Center.

We are here to dedicate a great new hospital and to honor those who contributed so much to making it a reality. As we do so, we pay special tribute to Governor James A. Rhodes and to those many others in our General Assembly and State Government who led the way with support and encouragement for this culminating project in the expansion of this medical center. Our attention cannot escape the physical facility itself—because there it is—only a few yards away, still rising up from the ground with all of the “sound and fury” of a great structure. We have all watched and listened as this building has grown by each steel rod and each bucket of concrete. From early morning until late afternoon, it has dominated our Medical Center landscape.

It dominates, not only because of its massive testimonial to engineering skills but because of its potential as a physical resource to help people from throughout the state. This new hospital will contain 362 beds, a new emergency department, a 30-bed recovery unit, nine new operating rooms, eight new diagnostic x-ray rooms, and many more technological improvements which will ensure our ability to meet our obligations as a complete medical center presently and in the years to come.

Yet, let us not forget that this new hospital facility is only a symbol of something else. Other buildings at other times over the past 30 years have dominated our physical horizon. As the clatter of construction ended on each one, we moved into it and began the job it was meant to help us do—help teach tomorrow’s physicians, nurses, allied medical professions personnel, and many other students of health-related disciplines to do a better job of restoring good health to the ill. When the need has arisen, we have built other buildings with the help of our governmental leaders and the friends of this Univer-



Mr. Martin Beerman, President, Medical Student Council, The Ohio State University College of Medicine, participates in the cornerstone sealing of the James A. Rhodes Hall.

sity, but each time a building was completed, it became a symbol, a token of the true heart of this great Medical Center—excellence in education, research, and patient care.

Buildings don’t stand as monuments. They are the means by which we achieve growth and even higher potential for the people they were intended to serve. Ten years ago, The College of Medicine enrolled 150 students each year. This year, that number is 233 and with this new hospital addition, we expect to enroll a class of 264 students in the future. In the past decade, we have also increased the enrollment of our nursing students by 110—from 150 to 260 students. And in the School of Allied Medical Professions, we have grown from an enrollment of 264 students to 660 today.

We are proud of our nationally and internationally acclaimed independent study program for medical students. We are pleased to say that more than half of the computer-assisted instructional programs in Medicine in the United States were developed right here at O.S.U.

We are proud that, along with the growing age of both technical and medical specialization, two-thirds of our College of Medicine graduates are now expressing a preference for entering primary care fields in response to societal needs.

Code Defines Practitioner Of Medicine or Surgery

Section 4731.34, Revised Code, provides in part as follows:

"A person shall be regarded as practicing medicine, surgery, podiatry, or midwifery, within the meaning of sections 4731.01 to 4731.61 inclusive, of the Revised Code, who uses the words or letters, 'Dr.,' 'Doctor,' 'Professor,' 'M.D.,' 'D.S.C.,' or 'Pod.D.,' 'M.B.,' or any other title in connection with his name which in any way represents him as engaged in the practice of medicine, surgery, podiatry, or midwifery, in any of its branches, or who examines or diagnoses for compensation of any kind, or prescribes, advises, recommends, administers, or dispenses for compensation of any kind, direct or indirect, a drug or medicine, appliance, mold or cast, application, operation, or treatment, of whatever nature, for the cure or relief of a wound, fracture or bodily injury, infirmity or disease"

Section 4731.41, Revised Code, provides in part as follows:

"No person shall practice medicine or surgery, or any of its branches without a certificate from the State Medical Board; no person shall advertise or announce himself as a practitioner of medicine or surgery, or any of its branches, without a certificate from the board; no person not being a licensee shall open or conduct an office or other place for such practice without a certificate from the board; no

person shall conduct an office in the name of some person who has a certificate to practice medicine or surgery, or any of its branches."

All persons not holding a license from the State of Ohio Medical Board including Physicians' Assistants, Extenders and Paramedics are persons prohibited from practicing medicine or surgery by the provisions of sections 4731.34 and 4731.41, Revised Code, as stated afore-said. Such persons shall not admit anyone to a hospital or release anyone from a hospital, shall not diagnose or treat, and shall not prescribe drugs.

Fully licensed physicians employing or using services of persons to assist them who are not licensed by the State Medical Board are responsible for making certain that such persons are not practicing medicine or surgery and that services performed by such persons are performed in the immediate presence of and under the direct supervision of such duly licensed physicians.

Grant to Northeastern Ohio Univ.

Northeastern Ohio Universities College of Medicine has been given a Health Professions Capitation Grant of \$46,600 for the period July 1, 1976 through June 30, 1977. The College of Medicine will use these funds in part to accelerate the development of self-teaching materials and procurement of other resources to enrich the proposed Phase II curriculum. This curriculum encompasses the medical-school phase of the six-year, 11-month, B.S./M.D. degree program.

(continued on page 608)



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From the President

GEORGE N. BATES, M.D.

I am pleased to announce that The Physicians Insurance Company of Ohio (PICO) has received the appropriate authorization of the Ohio Department of Insurance to commence the sale of its stock by means of an Offering Circular to OSMA members and Ohio medical partnerships and corporations. This means we are now able to begin capitalization of the medical professional liability insurance company which the special session of our House of Delegates voted to form.

Each of you will soon be contacted by a representative of The Ohio Company regarding the purchase of this stock. I urge you to consider the following:

(1) All OSMA members are asked to purchase stock even if the individual member does not contemplate any availability or price problem concerning medical professional liability insurance in the near future. We ask that every member support this move by the OSMA and exhibit this support by a stock purchase.

(2) We anticipate that many members will initially be able to purchase medical professional liability insurance from PICO at a cost savings. As an example, the Joint Underwriting Association (JUA) will be more expensive because of the JUA's Stabilization Reserve Fund surcharge. Even with the one-time purchase of PICO stock, most members will save money.

(3) The private marketplace continues to evaporate in Ohio. Already, Shelby, Aetna, and other insurance companies have announced their intent to cease sales of medical professional liability insurance. Buckeye Union has announced it will no longer sell professional liability insurance to lawyers. Can physicians be far behind?

(4) No one, however, will be able to buy medical professional liability insurance from PICO unless the necessary capitalization figures are achieved. Therefore,



it is important that all physicians consider the purchase of stock.

An Offering Circular has been mailed to all members outlining the organization of the Physicians Insurance Company of Ohio and explaining some of the insurance considerations involved. This Offering Circular also includes the initial premium rates that will be filed by PICO with the Ohio Department of Insurance. I urge every physician to review this document carefully as sales are only to be effected by means of this Offering Circular.

I think we have made a good beginning and believe that time will prove the correctness of the decision to form our own insurance company. We anticipate that PICO will be the best physician-owned insurance company in the United States.

George N. Bates, M.D.



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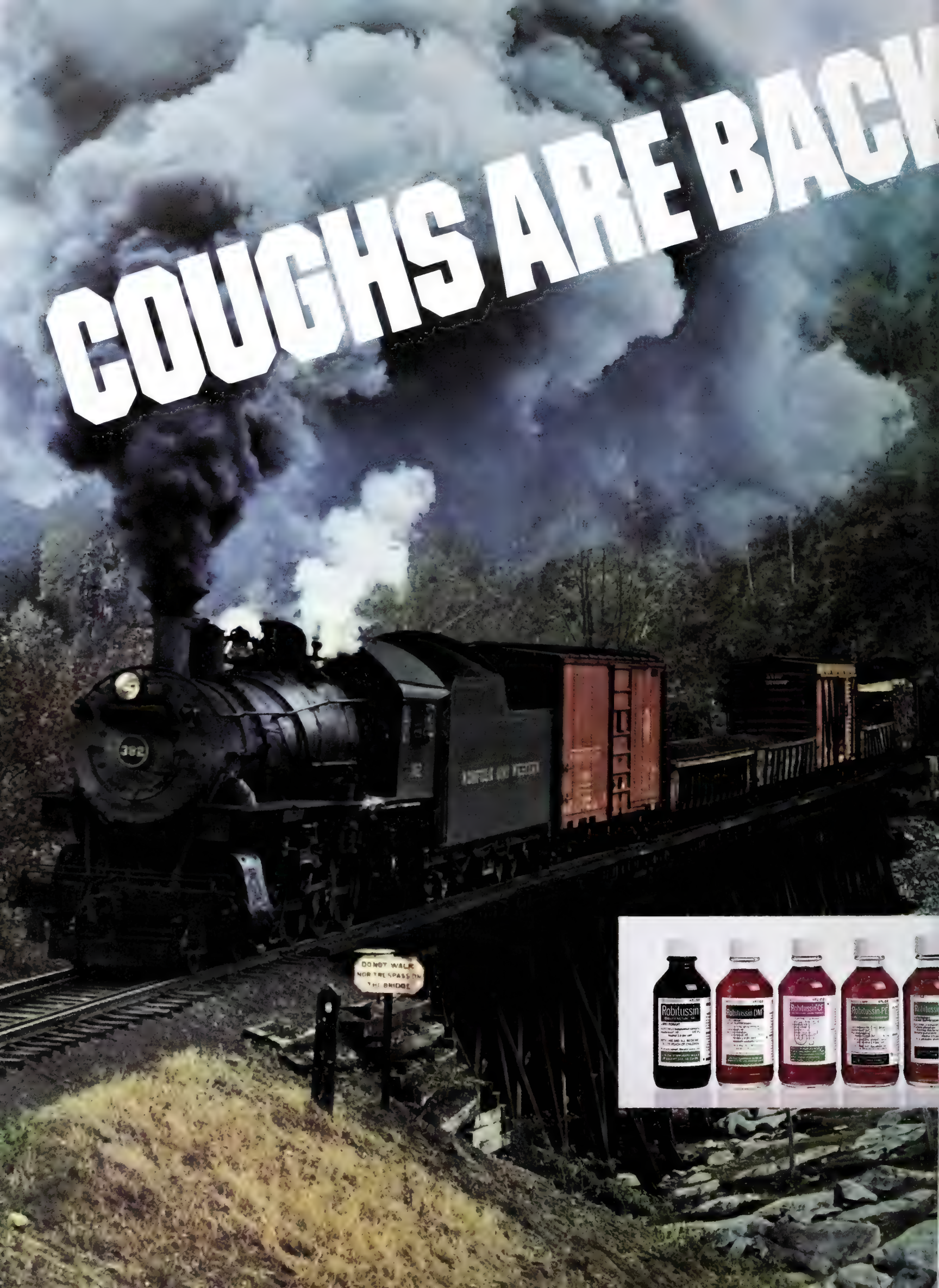
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP	24.0 mg.
(equivalent to paregoric 6 ml.)	
(warning: may be habit forming)	
Sodium benzoate	60.0 mg.
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Alcohol, 5%	

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Non narcotic for 6-8-hour cough control

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Each 5 ml teaspoonful contains:
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Hydrobromide, NF 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus
openings as it helps relieve coughs

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Each 5 ml teaspoonful contains:
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Pseudoephedrine
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Alcohol, 1.4%

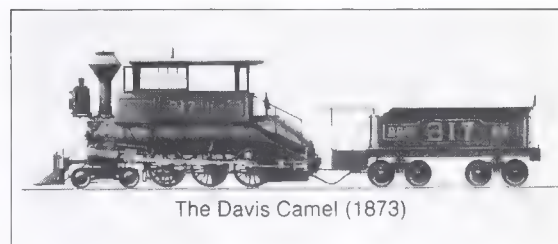
Decongestant action helps control cough and
clear stuffy noses and sinuses. Non narcotic.

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Each 5 ml teaspoonful contains:
Guaifenesin, NF 50 mg
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Hydrochloride, NF 12.5 mg
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Alcohol, 1.4%

All Robitussin formulations available on your
Rx or Recommendation.

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The Davis Camel (1873)

OUR PHOTO: Norfolk & Western Branch Train
No. 202 west bound near Alvarado, Va. (Oct., 1956).
This line reaches the highest point of any railroad
East of the Rockies (elevation 3,577 ft.) with a
minimum grade of 3%. It crosses 108 bridges,
some 700 ft. long! Photo by O. Winston Link.

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Sodium Azide Disposed of Down Drains Could Explode

Hospital and clinical laboratories risk an explosion where the chemical sodium azide is disposed of down drains with waste liquid, according to the National Institute for Occupational Safety and Health (NIOSH). The NIOSH reports that this potential hazard exists in plumbing systems where the chemical preservative, sodium azide, used in diagnostic equipment such as automatic blood-cell counters, is disposed of. The azide is not water soluble; and it accumulates in the pipe linings, eventually reacting with copper, lead, or brass to form a highly explosive substance. Surface friction, which could be caused by metal probes or saws, may cause an explosion. Three explosions in Los Angeles County hospitals this year were attributed by NIOSH to this condition.

Monthly Medical Board Report

The Medical Board of the State of Ohio has made available the following enforcement statistics covering the period July 1 to August 1, 1976:

1. Six individuals were requested and appeared at the Board offices to discuss and explain potential violations of the law.

2. Two individuals voluntarily surrendered their medical licenses.

3. The Board held one formal hearing.

4. The Board issued three formal citations under the Medical Practice Act.

Private Management of N. Carolina Medicaid Program Terminated

The only arrangement for private management of a state's medicaid program has been terminated. Health Application Systems and the State of North Carolina "mutually terminated" their \$405 million, two-year contract under which the company agreed to take over the program for a fixed fee. During negotiations that began late in May, the company said that the State, by increasing nursing home reimbursement rates, had provided the incentive for the expansion of long-term care facilities in the state, which further increased the costs of the Medicaid program. The company also claimed that the State, in negotiating the original contract, underestimated the number of persons eligible for Medicaid.

The settlement, which was announced August 11 and is retroactive to June 30, calls for the State to assume the increased cost stemming from the rise in nursing home utilization and the company to assume costs associated with increased enrollment in the Medicaid program. The company will continue to serve as a fiscal intermediary for the program until June 30, 1977, or until a new con-

(continued on page 611)

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is driving them apart



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Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101, Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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tract with the State is negotiated. State officials are preparing to solicit competitive bids on management of the program, and a spokesman for Health Application Systems says the company plans to submit a bid.

Ohio Medical Schools to Develop Instructional Materials Jointly

Ohio's six medical schools have received a grant from the National Library of Medicine to establish a regional consortium for developing and testing innovative medical instructional materials. The Ohio Regional Medical Audiovisual Consortium is based in Columbus; its activities will emphasize the design and testing of an inter-institutional approach to development of medical learning materials. In addition, the schools will have a mechanism to improve sharing and use of new and existing medical instructional resources, to determine the priorities for future instructional systems, and to develop an applied educational research program. This grant marks the first time such cooperation has occurred among the six schools.

The grant requires the development of six packets of self-instructional materials having a modular approach. Each unit will be in a flexible format which may be modified by member institutions to meet their own curricular needs. Technical quality and learning effectiveness of the products will be extensively evaluated.

Topic areas for the first three programs include pediatric teaching materials on normal human growth and development, clinical science materials emphasizing the taking of histories and interviewing, and cancer education.

Licensed MD Must Supervise ER

Every patient seen in an emergency room in Ohio must be the medical responsibility of a fully licensed physician (Sections 4731.34 and 4731.41, Revised Code). Physicians in approved training programs who are on duty in the emergency room but who are not fully licensed shall be supervised by a fully licensed physician who is immediately available. The emergency room medical record of each patient must be signed by a fully licensed physician.

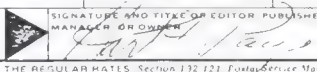
Physicians' Organizations Cease Using Relative Value Scales

Two physicians' organizations have agreed to stop using relative value scales, in compliance with an order of the Federal Trade Commission (FTC). The FTC said the scales, which assign ratings to services according to their importance, could be converted to a price guide

through the use of a multiplier, making it easy for physicians to fix prices. The American Academy of Orthopedic Surgeons and the American College of Obstetricians and Gynecologists, which together have a membership of nearly 20,000 physicians, consented to withdraw existing value scales but maintained that such value scales do not violate the law. Both groups said that they consented to the FTC order to avoid costly and time-consuming litigation. The FTC order is part of its recently announced investigation of costs in the health care field.

Medical History Society Established at Wright State

A Society for the History of Medicine and Health Sciences has been formed at Wright State University to give faculty, staff, students, and residents of surrounding *(continued on page 619)*

U.S. POSTAL SERVICE STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION Publication of Section 3685		
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comments

(Editor's Note: These comments concern the clinical and scientific article "Alcoholism— Three Points to Remember," written by Philip E. Hinkle, M.D. This article appeared in *The Journal*, Volume 72, Number 7, page 389.)

Alcoholism Article Draws Comment

I wish to congratulate you upon the rare honor of having your undergraduate paper published in the July issue of *The Ohio State Medical Journal*. It is both erudite and sincere and it must be congratulated for its depiction of the drunkard's predicament. But is Alcoholism a disease? Is Alcoholism more a "disease" than Nicotinism or Caffeinism or the gripping addiction, not peculiar to medicine, but shared by many physicians, that I choose to call Silas Marnerism? Since a disease is what the doctors say a disease is, almost any smart physician can have a syndrome named after himself—in fact, many do. If Silas Marnerism be proclaimed a "disease" characterized by an obsessive addiction to accumulating and preserving income, can one not only predict the outcome of the indolence, overeating, overindulgence, and professional hubris, all of which, similar to alcohol, lead in return to an absorption in a passion which does not cloy the appetite but which exhausts all the interest and energy not spent in acquisition.

What does Dr. Hinkle have to say about these diseases; are they a new kind of medical responsibility? Do we need new medical specialists to treat them, the former to be called Alkaloidologists, the latter Medico-financologists who require an added degree from Wharton College? But before creating new specialties or further atomizing our present ones may we not wonder a bit whether human conditions such as boredom, alienation from work, detachment from family ties, rootlessness, loneliness, absence of heroic models, fear of close human contact, the stress of competition and the constant anxiety of disappointment may be— to use the medical model—precursors of the several diseases suggested above.

To call the failure of our social system to lift, sustain and inspire men a "disease" of society might be less a cop-out than to label the consequences of a chronic toxic addictive state the cause of the alcoholic disease. I leave you with these thoughts and hope that your generation will come to look upon alcoholism as the fear to face or deal with apperceptions that cannot be tolerated in the sober state! Perhaps these complications can be prevented, not with vitamins or other nostrums, but with the provision of meaningful and satisfying work, a prescription for cooperation instead of competition, offering circumstances under which people can engage in friendly social intercourse and mutual help, the removal of bigotry and the provision of safety and security to the aged and to the weak.

Now for a final word— before introducing the notion of demonology in that alcoholism is an evil invasion from the outside of self, you should consider, I think, that everyone has an obligation for self-control and for his own moral responsibility. Man may be a victim of his vices, but he is also their author.

With best wishes for a successful and fruitful career.

Laurence M. Weinberger, M.D.
Summit County Society
Akron, Ohio (Retired)

Dr. Hinkle Replies

One interpretation of traditional wisdom has dictated that alcoholism is merely a vice, a moral weakness which is evidenced by overindulgence in a worldly pleasure; it has been compared with other "habits" such as overeating and excessive smoking. One of the failings of this traditional concept is its inability to explain the progressive nature of alcoholism. The extent of the loss of control and the extent of the physical addiction revealed when the abstinent alcoholic returns to alcohol is not stable over a period of time. An individual who is an alcoholic at an early age may abstain from alcohol for several years. If drinking is resumed, the alcoholic will not merely return to the poor level of control suffered previously, but will show a marked reduction in ability to control the amount of his/her drinking. This progressive loss of control continues whether or not the individual has drunk in the specific time period in question. This observation has been well described but little recognized.¹ It suggests that alcoholism may be a more complex illness than implied by an analogy with other excesses which remain relatively stable over a period of years— eg, overeating.

There has been much diversity of opinion regarding the etiology of alcoholism. Two of the traditional viewpoints have emphasized either a moral inadequacy present in the alcoholic or a deep-seated conflict of psychosexual origin. As a result, treatment has ranged from delivering moralizing sermons to psychoanalytic digging into the recesses of the past. The most striking similarity of these varied philosophies has been their consistent failure. In contrast, a lay organization, Alcoholics Anonymous (AA), has enjoyed continued success over the years. Many physicians have elected to retain their preferred ideologies despite the failure of their treatment approaches. However, a growing number of physicians are adopting a new treatment approach based on the careful application of the principles of AA.² Alcoholism is regarded as a primary illness and not the mere symptom of underlying pathology; emphasis is placed on the recognition and treatment of the alcoholic drinking pattern itself. The success enjoyed by those who have developed this new approach has encouraged the recent public awareness of the ubiquitous problem of alcoholism.

A broad view of history reveals that in cases where two opposing ideologies conflict, the ultimate victor usually will be determined pragmatically. The approach that works best will prevail over those having a lesser efficacy.

Philip E. Hinkle, M.D.
Resident in Psychiatry
The Ohio State University Hospitals
Columbus, Ohio

1. American Medical Association: *Manual on Alcoholism*, Chicago, 1973, p. 4.
2. Johnson, Vernon E: *I'll Quit Tomorrow*, New York, 1973, pp 1-168.

Doctors Aren't Mechanics

Count us among the last to doubt that such a thing as Medicaid fraud exists. But the tactic of "proving fraud" by sending a certifiably healthy specimen to the doctor smacks of showboating at best. It doesn't prove anything.

Sen. Frank Moss (D-Utah), chairman of a Senate subcommittee on long-term care, had been pronounced in perfect health before going to a clinic in New York City and telling a doctor he thought he might have a cold.

He was given a costly series of tests and told to come back the next day for more.

We are in no position to either condemn or defend the doctor; we can only point out the difference between a doctor dealing with a human being and a mechanic dealing with a car. Mechanics have been the subjects of similar tests, conducted by the *Beacon Journal*, among others.

A mechanic can get behind the wheel and drive the car. If it seems perfect, a good, honest mechanic is obliged to say so. A doctor, no matter how good, cannot climb into the skin of another person and say how he feels.

If someone goes to a doctor and says he feels bad, the doctor must take his word—and find the cause, if possible. That means tests.

And as long as the test results are negative—as they would be with a healthy patient—the doctor has to continue testing for other possible causes for the ailment. At some point, of course, the doctor must give up. But not before he has exhausted the possibilities.

Sen. Moss was also given prescriptions for three drugs. Again, we do not know what the drugs were, but it is not all that unusual for a doctor, in doubt about the cause of an illness, to prescribe reasonably safe, broadside medication in the hope that it hits something.

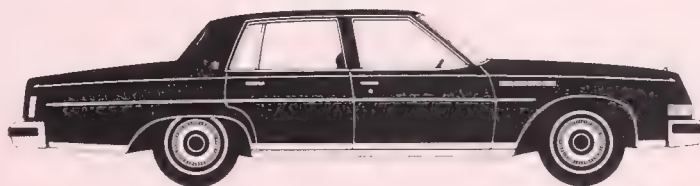
There is, quite likely, fraud in Medicaid. There may even be fraud committed by the clinic Sen. Moss visited. But when a healthy person tells a doctor he's sick, it's not the doctor who is committing fraud.

(Reprinted from the *Akron Beacon Journal*, September 2, 1976)

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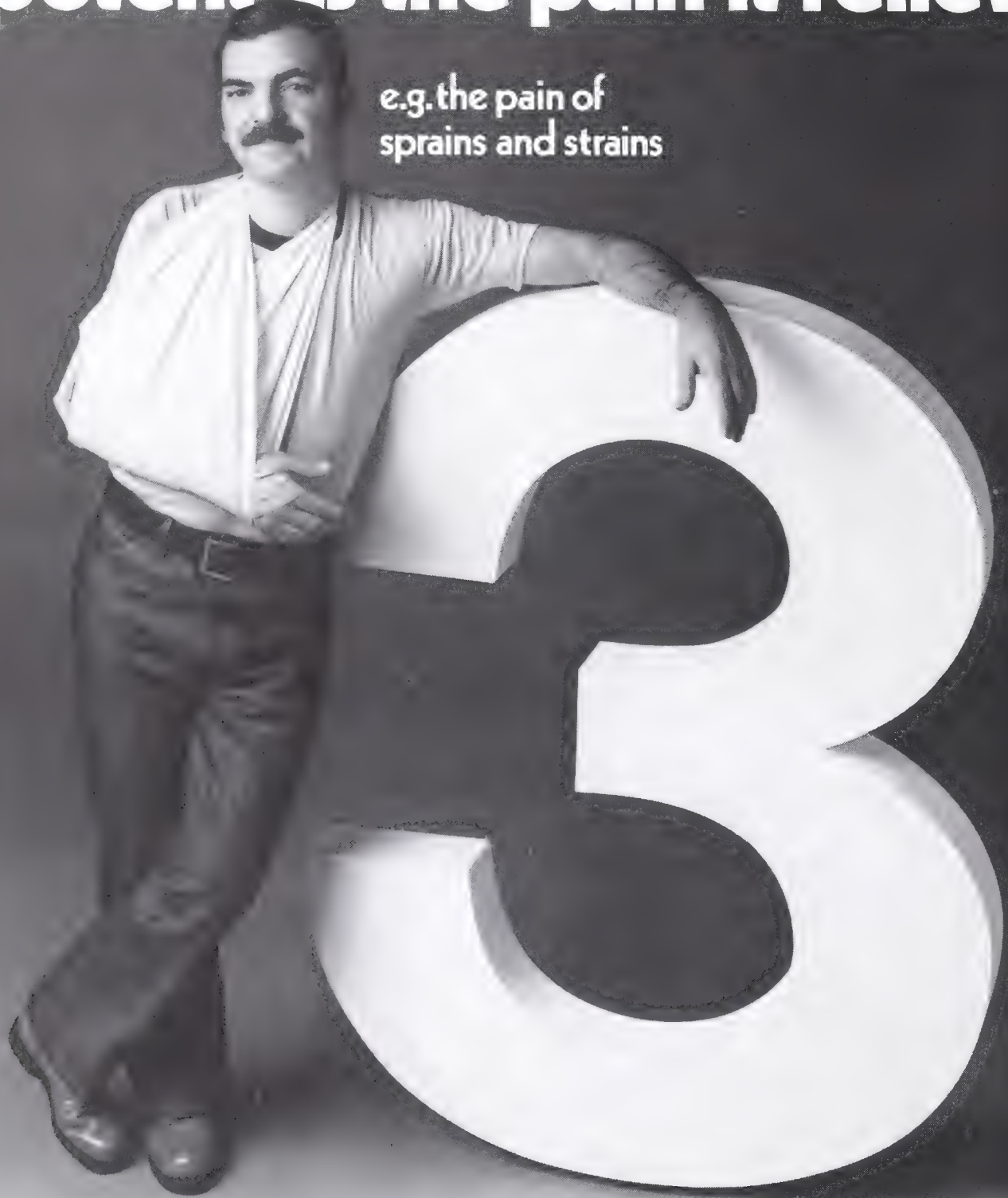
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Legislative Update

After three months of hearings and a week of legislative debate, the Ohio Legislature passed a bill which will pump millions into the financially plagued Medicaid program. House Bill 1546 provides for the funds through \$50 million in supposed cost-savings programs and \$109.5 million in state and federal matching funds.

State Representatives Myrl Shoemaker, William Mallory, and Ben Rose spent the late hours of Friday, September 17, in a conference committee with Senators Harry Meshel, William Bowen, and Paul Gillmor of the Senate in a final attempt to bring out a bill that would both provide the necessary funds and be more than a short-term, stopgap proposal. No one at the Legislature believes HB 1546 is a total answer to the current Medicaid crisis, but most feel this bill will resolve some of the problems currently plaguing the Medicaid system.

In an attempt to reduce over-utilization, the legislation requires written authorization by the Welfare Department prior to the administration of services by anyone but medical or osteopathic physician providers. Further, the Department is required to establish and reimburse Medicaid clinic services at a customary clinic charge and to reimburse medical laboratories at a rate not to exceed the usual charge for a laboratory profile.

The bill includes administrative procedures and controls covering the following areas:

(1) Elimination of payments to physicians for hospital visits when the fee charged should have been part of the surgical fee;

(2) Elimination of so-called "double" reimbursement to physicians and outpatient hospital clinics for pre- and post-delivery, where both entities were billing for the same services;

(3) Authorization of routine, newborn infant care on the basis of a single fee;

(4) A limitation of inpatient days to a maximum of 60 per year without prior authorization; and

(5) Reduction of maximum allowable quantities of prescription drugs and elimination of reimbursement for over-the-counter drugs.

The Legislature included the following sections over the objections of the OSMA:

(1) Preadmission certification for elective surgical procedures,

(2) Denial of reimbursement to any provider who *knowingly* renders services to persons ineligible to receive Medicaid services, and

(3) Requirement for the Department to develop a plan to utilize PSROs to review admissions and length of stay and other aspects of welfare patient care.

On the whole, the OSMA got the legislature committee to accept most of its amendments to HB 1546. The cooperation between OSMA and the Legislature in this complex area of Medicaid reform will hopefully continue as the Legislature and the Department of Welfare attempt to implement the bill.



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S-3.	6	60	_____	_____	_____	_____
S-4.	6	60	_____	_____	_____	_____
S-5.	3	30	_____	_____	_____	_____

S-6.	3	30	_____
S-7.	5	50	_____
S-8.	3	30	_____
S-9.	3	30	_____
S-10.	3	30	_____
S-11.	11	130	_____
S-12.	6	60	_____
S-13.	6	60	_____
S-14.	6	60	_____
S-15.	6	60	_____
S-16.	6	60	_____
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S-18.	3	30	_____
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Special Note • In addition to the postgraduate courses outlined here, the Oct. 11, 1976, JAMA Convention Issue contains 9 general sessions, 16 luncheon sessions, and 32 "Meet the Professor" meetings available to you. The AMA's Philadelphia Clinical Convention Brochure also contains this information. All inquiries should be directed to the **AMA Department of Meeting Services, 535 N. Dearborn St., Chicago, IL 60610** and/or direct phone inquiries to: **AMA Department of Meeting Services at (312) 751-6187.**

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materials will be sent to you on November 12, 1976. All tickets requested after that deadline date will be held for pickup at the Postgraduate Registration Desk in the Philadelphia Civic Center.

If the minimum course registration is not attained for your first choice, or if the course is full, one of your alternate choices will be substituted. It is best to register early because the class sizes are limited. All medical students, interns, and residents are entitled to a 50% discount on postgraduate course fees (\$10 per Category 1 credit hour is standard rate).

Postgraduate Courses

Saturday, Dec. 4, 1976

7:30 AM-Noon (5 hours: \$50)

- *S-1. Basic Life Support (Cardiopulmonary Resuscitation—CPR)

9:00 AM-5:30 PM (6 hours: \$60)

- S-2. Practice Management Seminar
- S-3. Writing for Scientific Journals
- *S-4. Nutrition: Parenteral & Alimentary

9:00 AM-Noon (3 hours: \$30 each)

- *S-5. Basic Electrocardiography
- S-6. Evaluation of the Dizzy Patient

1:00-5:30 PM (5 hours: \$50)

- S-7. Basic Life Support (CPR)

2:30-5:30 PM (3 hours: \$30 each)

- S-8. Hematologic Disorders in Children
- S-9. The Eye & Office Practice
- S-10. Coronary Artery Disease: Medical vs Surgical Therapy

Sat., Dec. 4 & Sun., Dec. 5

9:00 AM-5:30 PM & 9:00 AM-Noon (11 hours: \$110, plus \$20 lab fee = \$130)

- S-11. Public Speaking Seminar

9:00 AM-Noon & 9:00 AM-Noon (6 hours: \$60 each)

- *S-12. Fluid & Electrolyte Therapy
- S-13. Diseases of the Bowel
- S-14. Arthritis Update: Medical & Surgical Management

2:30-5:30 PM & 2:30-5:30 PM (6 hours: \$60 each)

- *S-15. Management of Diabetes Mellitus
- S-16. Hypertension

Sunday, Dec. 5, 1976

9:00 AM-Noon (3 hours: \$30 each)

- S-17. Diagnosis & Treatment of Fractures of the Upper Extremities

- *S-18. Advanced Electrocardiography

- S-19. Emergency Medicine

2:30-5:30 PM (3 hours: \$30 each)

- *S-20. Pulmonary Function & Blood Gases
- S-21. Behavioral Problems Involving Children & Adolescents
- S-22. Recent Advances in Cancer Surgery

Sun., Dec. 5 & Mon., Dec. 6

7:30 AM-5:30 PM & 7:30 AM-Noon (12 hours: \$120)

- S-23. Advanced Life Support (CPR)

9:00 AM-Noon & 9:00 AM-Noon (6 hours: \$60)

- S-24. Jaundice: Diagnosis, Treatment & Management

2:30-5:30 PM & 9:00 AM-Noon (6 hours: \$60)

- S-25. Everything You Want to Know About New Diagnostic Techniques: Scoping, Scanning, & Angiography

Monday, Dec. 6, 1976

9:00 AM-Noon (3 hours: \$30 each)

- S-26. Diagnosis & Treatment of Fractures of the Lower Extremities

- S-27. Neonatology

- S-28. Current Controversies in Gynecology

2:30-5:30 PM (3 hours: \$30 each)

- S-29. Basic Electrocardiography

- S-30. Pulmonary Function & Blood Gases

- *S-31. Complications of Psychotropic Drugs

Mon., Dec. 6 & Tues., Dec. 7

9:00 AM-Noon & 9:00 AM-Noon (6 hours: \$60 each)

- S-32. Immunology 1976

- S-33. Thromboembolism: Prevention, Diagnosis, & Treatment

2:30-5:30 PM & 2:30-5:30 PM (6 hours: \$60 each)

- S-34. Fluid & Electrolyte Therapy

- S-35. Nutrition: Parenteral & Alimentary

- S-36. Management of Diabetes Mellitus

Tuesday, Dec. 7, 1976

7:30 AM-Noon (5 hours: \$50)

- S-37. Basic Life Support (CPR)

9:00 AM-Noon (3 hours: \$30 each)

- S-38. Diagnosis & Treatment of Fractures in Children

- *S-39. Dermatology for the Nondermatologist

- S-40. Allergic Emergencies

- S-41. Medical Problems in Long-Term Care

- S-42. Acute Hand Problems

1:00-5:30 PM (5 hours: \$50)

- S-43. Basic Life Support (CPR)

2:30-5:30 PM (3 hours: \$30 each)

- S-44. Advanced Electrocardiography

- S-45. Dermatology for the Nondermatologist

- S-46. Complications of Psychotropic Drugs

*Course repeated. See course list for dates & times.

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communities an opportunity to become familiar with the highlights of the profession. Organized by School of Medicine Professor Alvin E. Rodin, M.D., the Society aims to provide an informal atmosphere where people can discuss the influence of medicine on the course of history as well as the impact that other disciplines and historical events have had on the development of medicine and the related health professions.



Your doctor reports

In the October issue of *Your Doctor Reports*, your patients will learn about the overuse of nasal sprays, new studies on oral contraceptives, the concept of the Living Will, dangers associated with the use of space heaters, and what one of Ohio's newspapers thinks about the current Medicaid investigations. Be sure to put *Your Doctor Reports* in your waiting room this month.

Joint Underwriting Association Malpractice Insurance Premiums Rise

Physicians receiving bills for medical professional liability coverage from the Joint Underwriting Association (JUA) will note an increase in their premiums. This increase is due to one or more of these factors: (1) the first year premium was based on 45 percent of the Insurance Service Office (ISO) occurrence rate—the second year premium is 70 percent of the ISO occurrence rate; (2) there has been a 30 percent increase in the base JUA rate effective August 1, 1976; and (3) due to a few changes in insurance risk categories, a physician could be placed in a different risk category. Physicians with questions regarding their JUA premiums should contact the JUA office, 6230 Busch Boulevard, Suite 303, Columbus 43229. Telephone: (614) 436-4530, or (toll-free) 1-800-282-1772.

Ohio Department of Insurance Praises New PICO President

When public officials often take themselves much too seriously, it is refreshing to find one with a healthy sense of humor.

Such was the case with Joseph K. Gilmore who will be leaving the post of deputy director at the Ohio department on Sept. 13 to become president of Physicians' Insurance Co. of Ohio (PICO).

At official functions, Mr. Gilmore often took the

sting out of weighty insurance problems with just the right dash of Irish humor.

But if he is missed at the Ohio department it will be more because of the reputation he gained as a manager and as a knowledgeable regulator than as resident wit.

Ohio Director Harry V. Jump said of Mr. Gilmore's departure: "We certainly regret losing him. It is as if the department were losing its right arm."

A veteran of the Ohio General Assembly himself, Mr. Jump said it was a credit to Mr. Gilmore that he was able, through his knowledge of insurance to gain the confidence of the legislature in the first year he worked in those halls. Mr. Gilmore, it will be recalled, was instrumental last year in pushing for reform legislation on the malpractice insurance problem.

"He performed yeoman service with the legislation. He came to be looked upon as an authority in insurance matters," Mr. Jump commented regarding Mr. Gilmore's work in the legislature. Mr. Gilmore's accomplishments in the General Assembly are noteworthy because it is difficult for anyone to gain credibility on a subject as complex as professional liability.

Perhaps the highest measure of praise for Mr. Gilmore came from a number of insurance people whose remarks were similar. They said, in effect, "It will be very difficult to fill his shoes."

Mr. Gilmore will not be severing his involvement with the insurance business. But he will be going into a narrow portion of that business—the field of professional liability. So, if insurance problems, after September 13, seem to become more serious than they really are, it might be because the Gilmore wit is missing.

(Reprinted from *The State Underwriter*, September 1976.)



Have you seen the OSMA presidential medallion designed by Dr. and Mrs. Richard L. Fulton (above)? Immediate recognition of the OSMA president and past-presidents is possible by noting the medallion in the shape of the OSMA seal worn by the physicians and their spouses.

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To assure prompt delivery, when replying to an advertisement over a **Journal** box number, address letters as follows: Box (insert number), c/o **The Ohio State Medical Journal**, 600 South High Street, Columbus, Ohio 43215.

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EMERGENCY MEDICINE: Career opportunities available in E.D. medicine. Also short-term and locum tenens. Eight Ohio locations. Flexible work schedules and competitive remuneration. Paid malpractice, vacation, educational leave. Contact Doctor S. Spurgeon or J. W. Cooper toll-free 1-800-325-3982.

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EMERGENCY DEPARTMENT DIRECTOR: 20% administrative, 80% clinical, with national emergency room group in Ohio. Annual minimum guarantee \$55,000-\$65,000. Contact Drs. Cooper or Spurgeon 1-800-325-3982; Box 11241, St. Louis, Missouri 63105.

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PHYSICIANS WANTED: LaFollette Community Hospital, LaFollette, Tennessee, is seeking an emergency room physician for immediate placement. Also, in need of family practice physicians, OB-GYN, and pediatricians. Guaranteed \$30,000 per year. Completely furnished office building adjacent to hospital. Located in East Tennessee, 45 miles north of Knoxville. Contact J. B. Wright, Administrator, LaFollette, Tennessee 37766. Telephone 615/562-2211.

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The psychiatric staff and allied professionals are in the process of merging with the Wright State University School of Medicine, Department of Psychiatry, which is to be based at the Good Samaritan Hospital, to form a Department of Psychiatry and Mental Health within the hospital. Primary mission of the new School of Medicine is the education and development of primary care physicians. The merged Department will emphasize the training and continuing education of family practice physicians and residents, liaison psychiatry and collaborative training with allied professionals. Psychiatric residency program under development. Clinical appointment to the University faculty expected. Must also meet requirements for hospital privileges.

The main Center is housed on one floor (36,000 sq. ft.) of a new replacement general hospital with excellent facilities and accommodations. Salary competitive and commensurate with experience and qualifications. Liberal fringe benefits, including four weeks vacation, retirement, malpractice insurance, BC/BS, life insurance, etc. Contact: John A. Davis, Ph.D., Director, Good Samaritan Hospital CMHC, or Kenneth A. Welty, M.D., Director of Center's Psychiatry Department, 2222 Philadelphia Drive, Dayton, Ohio 45406, or telephone: 513/278-2612, ext. 2685.

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EMERGENCY PHYSICIAN: Columbus, Ohio. Established EM group with extensive continuing education plans needs an additional physician to improve staffing. Prefer physician who will have completed rotating internship by June 1976, with career orientation. Could accept qualified applicant for one year, July '76 - June '77. Busy EM practice in 600-bed, private teaching hospital with University affiliation (Mount Carmel Medical Center) and 250-bed private suburban hospital with 24-hour medical and surgical in-house coverage (Mount Carmel East Hospital). Must have Ohio license. At least 4 weeks vacation. Excellent starting income, meeting expenses, plus malpractice, hospitalization, disability and life insurance. Call Donald T. Evert, M.D., President, Emergency Services, Inc., 5979 E. Livingston Ave., Columbus, Ohio 43227, (614) 864-0566, 8:30 AM - 5:00 PM, Monday through Friday.

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NOVEMBER 1976
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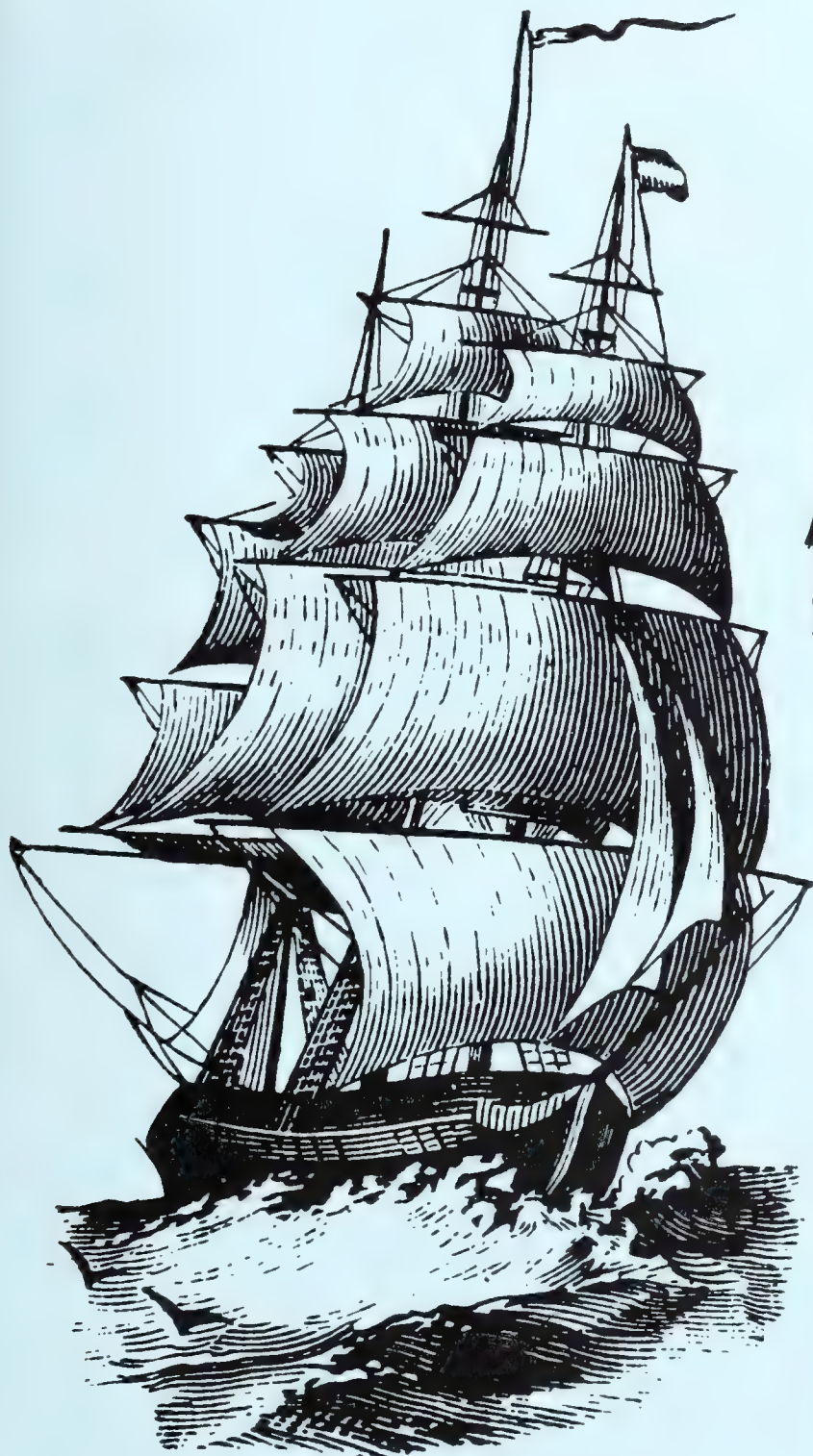


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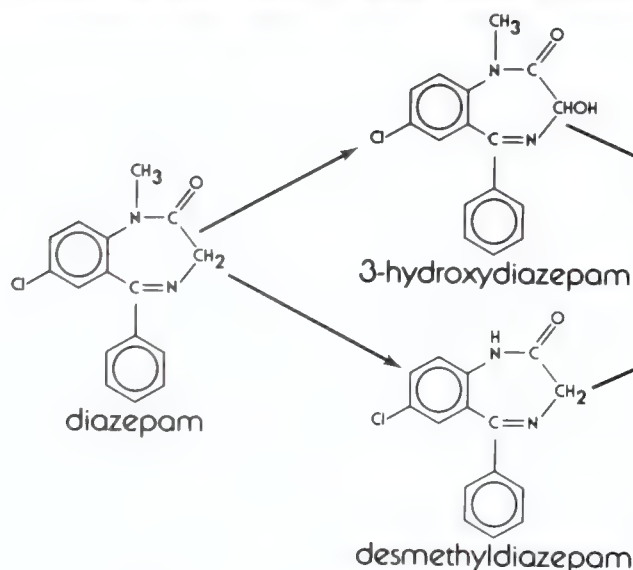
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COVER: Begin planning now to attend the 1977 OSMA Annual Meeting, May 14-18, in Columbus. The meeting will include a new concept: Category I continuing medical education programs to be held on Saturday, May 14. Two courses are already in the planning stage — one on negotiating and another on public speaking. Contact the OSMA Department of Continuing Medical Education for further information.

From the President

GEORGE N. BATES, M.D.

I am sure members of the OSMA are aware by now of the Ohio statute requiring physicians to complete 150 hours of continuing medical education (CME) during the period January 1, 1977 to December 31, 1979 in order to reregister their medical licenses in 1980. It is, therefore, increasingly important for the OSMA to become active in assisting physicians in this educational effort.

Recently, the OSMA staff reorganized to create the Department of Continuing Medical Education directed by Gail E. Dodson. This department will handle numerous aspects of CME including sponsorship of Category I programs, accreditation of organizations who wish to sponsor Category I programs, and planning of the OSMA Annual Meeting.

The Department of Continuing Medical Education will also supervise the OSMA Physician's Recognition Award program. I want to congratulate those physicians who, so far, have received the 1975 and/or 1976 OSMA Physician's Recognition Award. By achieving this award, you exhibit the commendable desire to keep current in the medical profession.

This issue of *The Journal* marks the beginning of a most interesting new feature— Ohio Medical School Highlights. We in Ohio are fortunate to have very fine medical schools, each with a personality of its own. This section is designed to inform Ohio physicians of the people and activities on these campuses. I especially want to thank the deans of these schools who have taken the time to write about medical education as undertaken by their respective schools.

Finally, I want to call your attention to the Continuing Education Programs feature which lists Category



I CME programs offered in Ohio. This listing will appear in *The Journal* on a monthly basis and will indicate courses available for the following two months. Sponsors of Category I programs are urged to use the enclosed form to submit information about the courses for publication.

George N. Bates, M.D.

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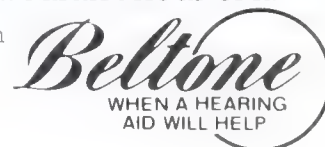
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Wright State University School

During September, Wright State University School of Medicine held a convocation for its first entering class. The school received 2,865 applications for places in this class which will graduate in 1980. Thirty-two students were accepted of whom 22 are male and 10 female. Ohioans number 30 of the 32; and of these, 12 are Dayton-area residents.

Class of 1980

The new medical students, who range in age from 21 years to 32 years, are Stephen O. Bernardon, Canton; Gary R. Biehl, Cincinnati; Cynthia H. Brand, Greenville; Robert L. Brandt, Xenia; Evan M. Cantini, North Canton; William A. Elder, Fredericktown; Susan M. Fesus, Uniontown; Roger D. Hazelbaker, Wilmington; David K. Hedden, South Euclid; Herman K. Hobohm, Akron; Carol J. Hubbard, Cincinnati; Peter C. Imber, Delphos; Walter W. Jacquemin, Hamilton; Randall D. Jenkins, Shaker Heights; Margaret Kokal, Cleveland; Marilyn K. Kosier, Ludlow Falls; John L. Lyman, Yellow Springs; Thomas G. Malcolm, Chicago, Illinois; Robert A. Mascia, Cincinnati; Robert J. Mathes, Dayton; Debra L. Murphy, Hobbs, New Mexico; Donald R. Neumann, Parma Heights; Robert J. Quellette, Fairborn; Richard H. Pearl, Findlay; Paul C. Perkins, Dayton; Ellen L. Sakornbut, Kettering; Carol A. Sauer, Perry; James J. Sell, Dayton; Sherry M. Stanley, Athens; Thomas M. Travis, Trotwood; Samia E. Warwar, Oakwood; and Paul Zeeb, Cincinnati.

Dean Beljan Heads Faculty

The Wright State University School of Medicine faculty is headed by John R. Beljan, M.D., Dean. Dr. Beljan has recruited 100 full-time faculty members and 500 voluntary faculty. Robert J. Kegerreis, Ph.D., is President of Wright State University.

Dr. Kegerreis noted in his remarks that it had long been the dream of the Dayton area to have a medical school. More than 16 years ago, community leaders tried to establish such a school. Dr. Kegerreis gave credit to the legislative and political leaders, the hospital administrators, and the physicians of the Dayton area for their influence in the development of Wright State University School of Medicine.

Dr. Beljan stressed that this school will generate a new breed of physician by providing a medical education geared to social need and conscience. In addition, Dr. Beljan paid tribute to the Dayton-area physicians when he noted, "One of the privileges of the position of dean is to work with the practicing physician."

A featured speaker at the convocation was John Worthman, M.D., President of the Montgomery County Medical Society. Dr. Worthman welcomed the Wright State University School of Medicine Class of 1980 to "the challenge and the delight of medicine."

Institutions Affiliate with School

Institutions that have affiliated with the School of Medicine include Charles R. Drew Community Health Center, Children's Medical Center, Community Hospital of Springfield and Clark County, Dayton Veterans Administration Medical Center, Good Samaritan Hospital, Greene Memorial Hospital, Kettering Medical Center, Mercy Medical Center, Miami Valley Hospital, St. Elizabeth Medical Center, and United States Air Force Medical Center at Wright-Patterson Air Force Base.

Changes in Medical Education Topic of Keynote Address

Keynote speaker was C. John Tupper, M.D., Dean of the University of California School of Medicine at Davis. The following is excerpted from his remarks to the Wright State University School of Medicine Class of 1980, their family and friends, and other individuals from the Dayton area.

Your school today becomes one of 114 American medical schools with students enrolled. It is one of a new generation of medical schools, of institutions that some have called schools without walls, for this school does not see itself as an ivory tower insulated from the people in the community about it but, rather, sees itself as a new community resource and asset and as a very real and functioning part of the community. It is a school that will make use of, gain support from, and contribute to the entire health, education, and delivery system of the community, and it is laying the groundwork for what I believe will be the future of medical education in terms of the intimate relationships and interrelations with the community.

Certain changes are taking place in medical education in the United States. In a way, a quiet revolution has occurred in our medical educational system to meet the changing demands of American society, and you are part of that quiet revolution.



f Medicine Accepts First Class

This has come about with very little fanfare and with none of the attendant disruptions which would be part of any governmental programs designed to bring about these changes. Because the changes are voluntary and evolutionary, there is every reason to believe that they will continue and that they will have a lasting impact on our medical delivery system.

The goal of the American Medical Association and of medical education for more first-line physicians has been attained early, in that 58 percent of all new M.D.'s are now entering primary care residencies or those in family practice, general internal medicine, general pediatrics, and obstetrics. Here, let me say that the term primary care refers to that physician who is the primary medical resource or counselor to an individual or to a family. When a patient needs hospitalization or other special medical services, the primary physician will see that the necessary arrangements are made, giving responsibility to others as appropriate, and retaining his or her own continuing and comprehensive care. Internists particularly function in this role, as well as family physicians, pediatricians, and obstetricians. It should be emphasized that primary care is a function, not a discipline.

But to continue, we have a record number of first-year medical students in the United States for there has been a 69 percent increase in the past ten years. The number of medical schools, as I mentioned before, has gone from 100 to 114, and there are 14 more in definitive planning.

We have a record enrollment of women, an increase of up to 360 percent in four years, so that now nearly one-third of medical students in school are women.

We do have this new emphasis on primary care. It is generally accepted that if there is a physician shortage in the United States, it is largely a degree of maldistribution, both geographically and by specialty. The concentration of narrow specialties over the past years has drawn away from the number of primary care physicians. It has also been shown that physicians trained for primary care, including family practice, have a greater tendency to settle in the rural areas. Specialty imbalance has helped to exaggerate the shortage of physicians in rural areas. The former emphasis on the specialties which had been removed from primary care has now been reversed. Of the 114 medical schools, 96 now report a teaching program in family medicine, while two years ago only 49 schools had such a program. Each year, the number of first-year medical students gets larger. In the 1974-1975 class, there was an increase of 3,188 entering American medical students over the preceding year. The total number of first-year students in the year just concluded was 14,963, and this year the number will exceed 15,000. Yet, with this continuing expansion, the quality of instruction which is carefully monitored by the Association of American Colleges and the AMA through the Liaison Committee on Medical Education, has remained high. For example, the student-faculty ratio continues at only 1.5 students for every instructor.

The attainment of this low ratio is the result of a phenomenon unique to the medical profession. One of every three physicians in the United States is a teacher, with the majority of these doctors teaching either part time or voluntarily donating time to a medical school. A total of 110,740 doctors teach at medical schools, 64,933 of whom donate their services.

The demand for admittance to medical schools continues to intensify. Over the past ten years, the number of applicants has risen by 122 percent. In those same ten years, the number of accepted first-year students has increased by 69 percent. Premedical academic records of the entering students have continued to improve. In the 1975-1976 class, nearly 40 percent of entering students had an academic average in the "A" range, slightly more than 50 percent in the "B" range, and only three percent in the "C" range.



Left to right: Andrew P. Spiegel, Ph.D., Executive Vice-President, Provost, and Treasurer of Wright State University; John Worthman, M.D., President of the Montgomery County Medical Society; and John R. Beljan, M.D., Dean of Wright State University School of Medicine.

And so change and evolutionary development continue. And on this base, the science of medicine for the future continues to be a hopeful one. Each year, we have thought we had reached an ultimate level in medical care, and yet each year new things become available and move from the research laboratory to the university teaching center to the teaching hospital. Corneal transplants are now regular activities and kidney transplants are becoming more so. Total hip replacements, total knee replacements, and replacements of finger joints are now quite well developed. We continue to see the development of new surgical procedures, as well as the means to replace surgical procedures with other approaches, or in combination. And we deal more effectively with cancer than we have in the past, as our knowledge of a link with viruses increases. Research continues to be of paramount importance, for it is the development of new knowledge on which our progress is based.

As a nation, we are showing increased interest in the problems of the cost of medical care, but we must be sure that the data upon which we base our concern are accurate. There is sometimes double reporting when surveys are made so that costs appear to be higher than they actually are. We continue to struggle with ideas about the organization of medical care in the United States when we have perhaps the best system of medical care in the world as it is. In my judgment, the source of our strength is volunteerism and private enterprise.



Dean Beljan introduces the faculty.

The Journal Corrects Error in Physician's Assistant Article

On page 603 of the October 1976 issue of *The Ohio State Medical Journal*, the following statement was made:

Fully licensed physicians employing or using services of persons to assist them who are not licensed by the State Medical Board are responsible for making certain that such persons are not practicing medicine or surgery and that services performed by such persons are performed in the immediate presence of and under the direct supervision of such duly licensed physicians.

This statement was written prior to the passage of Amended Substitute House Bill 663, The Physician's Assistants' Act. The law requires a physician to supervise a registered physician's assistant in the following way:

Section 4730.02 (A) The Physician's Assistant shall function under the supervision and control of a physician or physicians. Supervision requires the availability of a physician for consultation and direction of the actions of the assistant, but does not necessarily require the personal presence of the supervising physician at the place where services are rendered. The Physician's Assistant may provide services only to patients of the employing physician or physicians. He may function in any setting within which the employing physician or physicians routinely practice

AMA Warns Physicians of Hazards of "Going Bare"

According to the AMA, the physician who "goes bare"—practices without malpractice insurance—runs a risk of complete financial ruin.

A recent survey of physicians found that 35 percent of physician respondents said they are thinking of dropping malpractice coverage, while 13 percent said they are currently without malpractice insurance.

"Going bare" is a good idea "only for the very few tough-minded individuals who can live with the possibility of losing everything they've acquired in a lifetime of practice, plus a good chunk of their future earnings," W. Fred Mangan, head of a Michigan management consultant firm, told the *American Medical News*.

If the doctor drops his malpractice insurance, the only way he can keep from losing his assets in a future malpractice action is not to have any assets to lose. He has to give them away, Mangan pointed out, with the give-away complete and irrevocable and the doctor retaining no control over the assets.

Some physicians have considered putting all property in their wife's name, but, says Mangan, the chances of losing everything through divorce are much greater than any risk from malpractice. He points out that the American divorce rate is now 43 percent of all marriages.

If the doctor has no insurance and few assets to pay a malpractice judgment, the plaintiff's lawyer likely will

obtain a court order attaching future earnings. Medicare, Medicaid, Blue Shield, and insurance companies could be ordered to send checks to the plaintiff rather than the doctor; the doctor's bank accounts could be attached; and the plaintiff even could have someone sit in the doctor's office and collect all money paid by patients.

The doctor who "goes bare" may end up exactly that—bare.

AA Chapter Formed in Cincinnati

The International Doctors in Alcoholics Anonymous (IDAA) has formed a chapter in Cincinnati. For information call 513/683-8025.

"Lung Cancer—1976" Symposium Presented at Ohio State

The Division of Thoracic Surgery and the Department of Surgery of The Ohio State University College of Medicine, the Comprehensive Cancer Center of The Ohio State University, and the Working Party for Lung Cancer of the National Institutes of Health presented a symposium entitled "Lung Cancer—1976" during October. The symposium was presented in conjunction with the fall meeting of the Working Party as a memorial to the late Frederick E. Jones, Jr., Columbus. Mr. Jones was a philanthropist, humanitarian, civic leader, and trustee of The Ohio State University, who strongly supported the College of Medicine. He and his wife gave generous grants to support medical research, education, and patient care. Through a bequest in his will, he requested the establishment and the endowment of the Karl P. Klassen Chair of Thoracic Surgery of The Ohio State University College of Medicine.

The program of the day brought together nationally and internationally known investigators to review the biology of lung cancer, the immunologic characteristics and immunotherapy of the disease, and the evolving patterns of treatment of this disease. Copies of the proceedings of the symposium can be obtained by writing James W. Kilman, M.D., Professor and Director, Division of Thoracic and Cardiovascular Surgery, 410 West Tenth Avenue, Columbus, Ohio 43210.

Hawaii Requires MDs to Carry Professional Liability Insurance

A new state law in Hawaii requires physicians to carry at least \$100,000 in professional liability insurance. In addition, they must have insurance prior to being licensed. The constitutionality of this law, which became effective September 1, will be contested by the Hawaii Medical Association.

Changes Made in OSMA Executive Staff

Recently, The Council of the OSMA made a number of executive staff changes. D. Brent Mulgrew, Esq., was promoted to the position of Director of the Department of State Legislation. Mr. Mulgrew, who was the Assistant Director of the Department, replaces David L. Rader who has joined The Physicians Insurance Company of Ohio as Vice President- Administration.

The Council also approved the formation of the OSMA Department of Continuing Medical Education. Gail E. Dodson, formerly OSMA Convention Coordinator, was appointed Director of the Department; and Douglas R. Houser of the OSMA staff was named Assistant Director.

AMA Disagrees with Carnegie Foundation Health Manpower Report

A health manpower report, issued in September by the Carnegie Foundation, warned that the nation is in danger of developing too many medical schools. It said, "the chief reason for new medical schools now is to achieve more adequate geographical distribution of schools." In 1970, the same group had recommended expansion of medical school building.

Commenting on the report, an AMA spokesman said the AMA has "never taken the position there are too many medical schools, and we disagree with (the report's) proposal to determine exact numbers and locations of schools . . . We don't see any evidence of an excess of physicians. Although we do acknowledge a differential rate of growth, we aren't ready to sound the alarm."

Public Satisfied with Value Gotten for Health Care Dollar

According to Burns Roper, the public believes it is getting top value for its health care dollar. President and Chairman of the Board of the Roper Organization, Inc., New York City, Roper reported recent survey findings on health care issues polled.

Reporting the results of a poll taken last December, Roper said that "improving and protecting the nation's health was the one issue out of 12 on which the fewest people felt that we're spending too little money." By a ratio of nearly two to one, those persons polled indicated support for greater spending on health.

When those polled were asked what they felt contributed most to the increased cost of health care, it was found that hospital costs were first, having been cited by "more than 7 in 10 responses."

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New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.



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ohio medical school highlights

(**Editor's Note:** *The Journal* is pleased to initiate a section devoted to the medical schools of Ohio. This monthly feature will spotlight the people and events at each of the schools. In addition, an article by one of the medical school deans will appear on a bimonthly basis. *The Journal* hopes Ohio's physicians will become increasingly informed of the activities of the state's medical schools through this monthly column. In keeping with this education issue, each of the deans has written a synopsis of medical education as carried on at his particular school.)

Case Western Reserve University School of Medicine

Frederick Robbins, M.D., Dean

This opportunity to address the practicing physicians of Ohio and to report briefly on activities of Case Western Reserve School of Medicine (CWRU) is indeed welcome. Academicians and clinicians tend to revolve in their own orbits, but interplanetary communication seems to be the order of the day.

As our medical school begins its 134th year of preparing young men and women for the practice of medicine, we feel that the school is meeting at least some of the challenges being made by society today to medical education and medical educators. In spite of all the new pressures to which we are attempting to respond and the expansion of our academic programs, we have retained the basic educational structure which was seen as a revolutionary development when our new curriculum was introduced in 1952.

In response to demands for more physicians, we have been steadily building to our present enrollment of 574; this represents an addition of 225 medical students to the total student body since 1967. The heightened awareness of the potential role of women in the medical profession is reflected in the steady increase in the numbers of women admitted to our School over the past decade. Presently, women represent 26 percent of the total number of students and comprise one-third of the Class of 1980. In addition, the minority program at CWRU has been innovative in its approach to meeting the needs of minority-student training and is considered one of the outstanding such efforts in the country.

Responsibilities for involvement outside of our academic walls are being undertaken in many areas as the school sees opportunities to make real contributions to the social and professional needs of the community.

The present emphasis on primary care has created a climate for making family medicine appealing to our medical students, and we are observing an increasing interest in our incoming classes in this specialty. Creation

of a new Department of Family Medicine affords an excellent opportunity to see how the subject can best be fostered as an academic discipline, for our integrated curriculum is an ideally flexible structure into which to fit this teaching without a major revolution. We are pleased by the recent establishment of two Family Medicine Residency Programs associated with our Department at Cleveland Metropolitan General and Fairview General Hospitals. Both programs have received provisional accreditation from the AMA.

We, like many other medical schools, are strengthening our continuing education programs, particularly in response to the state-mandated requirements in continuing education for relicensure. Our school was provisionally accredited by the AMA in 1975 to provide Category 1 experiences on a regular basis.

During this year, a broad-based program of educational pursuits utilizing traditional departmental activities as well as special courses has been launched. Efforts are also under way to build a more academic base to continuing education presently common to higher education. This development, coupled with increasing efforts to assist community hospitals in meeting their educational needs, has led to a number of interesting projects in a relatively short period of time.

Our unique Fifth Pathway collaboration with the new Northeast Ohio Universities College of Medicine (NEOUCOM) offers opportunity to those Ohio residents who have attended Mexican medical schools to practice medicine in Ohio. Although the medical degree is not awarded by either CWRU or NEOUCOM, students will receive a certificate from CWRU attesting to successful completion of a year of supervised clinical training in the affiliated hospitals of NEOUCOM. Then, after completing an accredited residency, they will become eligible for licensure and be "deemed to hold the equivalent of a degree of Doctor of Medicine" in Ohio. Our faculty is also working closely with NEOUCOM clinical teachers in developing their educational program.

Medical College of Ohio at Toledo

John P. Kempf, M.D., Dean

The medical educators who assembled in 1968 and 1969 as the cadre of The Medical College of Ohio at Toledo (MCO) developed as a goal for the new school's curriculum the integration of the basic and clinical medical sciences. The first students were admitted in 1969. As we look back today upon the progress of our

(continued on page 632)

Medical School Highlights *(continued)*

school, we can congratulate ourselves for partially achieving that goal. But much more effort will be necessary, particularly in the integration of basic science teaching in the clerkship programs, before we will have a genuinely integrated curriculum.

The curriculum at The Medical College of Ohio provides an interdisciplinary rather than a departmental approach to the fundamental principles of human and cellular biology, the pathophysiology of major diseases, contemporary community health problems, and the development of basic clinical skills. Early contact with patients is used to enable the student to appreciate the clinical relevance of the disease process.

The program, which has recently been expanded from 33 to 35 months, is divided into three phases. Phase I is a 15-week introductory course in biological concepts of disease, which is designed to present those aspects of human and cellular biology essential to understanding the disease process. Phase II is an 18-month series of courses in systemic medicine which integrate the basic science and clinical aspects of each organ system. Sequences include hematology, oncology, immunology; cardiovascular system; respiratory system; digestive-nutrition; metabolism-endocrinology; reproductive system; urinary system; nervous system and behavior; locomotor system; and infectious diseases and therapeutics. Phase III further develops clinical skills through a system of clerkships in which the student is part of the health-care team with responsibilities appropriate to his level of training. Required clerkships consist of medicine, surgery, obstetrics and gynecology, out-patient services, pediatrics, and psychiatry. Preceptorships in a variety of medical specialties are also available. In addition, opportunities for independent study and student research are provided.

The program is extremely demanding upon the time of the faculty who must plan in great detail the implementation of each phase. A faculty team composed of internists, surgeons, pediatricians, obstetricians, physiologists, anatomists, and biochemists, among others, must closely coordinate their efforts over a period of several months in each segment of the curriculum. This interaction has advantages for both the student and the faculty. The student is assisted in integrating for himself the various disciplines which he must bring to patient care. The faculty by common consent benefit immensely from the interdepartmental association with their colleagues in a variety of disciplines. Several shared research projects which cross departmental lines have developed as a consequence of this association.

For the future, we wish to continue our efforts to expand this integration into the clerkships. For example, the biochemists when making rounds with our endocrinologists on patients with diabetes can provide our senior students with a review of the Krebs cycle and other basic biochemical phenomena.

Such integrated systems of teaching as the one developing at MCO stress the importance of understanding biological processes in health and disease, and, hopefully,

will produce physicians more oriented to dynamics and a variety of points of view than those coming from traditional programs.

Northeastern Ohio Medical College

Robert A. Liebelt, M.D., Dean

Development of Northeastern Ohio Universities College of Medicine is proceeding on schedule. This unique venture in medical education has as its academic base a consortium of three state universities (The University of Akron, Kent State University, and Youngstown State University) and will utilize community hospitals located in Akron, Canton, Ravenna, and Youngstown as its clinical teaching centers.

Since its creation by the Ohio General Assembly in November 1973, Provost Stanley W. Olson, M.D., Dean Robert A. Liebelt, Ph.D., M.D., and Vice Provost for Administrative Affairs, Charles V. Blair have been appointed. E. Jay Wheeler, M.D., Ph.D., has been designated Director of the Office of Medical Education; and Mrs. Karen Brewer, formerly of the Cleveland Health Sciences Library, Medical Librarian.

Program chiefs appointed to teach the basic medical sciences include George S. Malindzak, Jr., Ph.D., physiology; Ferenc Hutterer, M.D., molecular pathobiology; J. Michael Kehoe, D.V.M., Ph.D., microbiology/immunology; Theodore J. Voneida, Ph.D., neurobiology; and Edward B. Truitt, Jr., Ph.D., pharmacology. Dean Liebelt will serve as Acting Program Chief of Anatomy, and Norman Taslitz, Ph.D., will direct the Gross Anatomy Teaching Program. Annabel G. Liebelt, Ph.D., Professor of Anatomy, is serving as Director of the Kirschbaum Memorial Research Laboratory. Plans call for a total of 26 medical sciences faculty appointments by July 1, 1977.

Community physicians engaged either full-time or as volunteers in hospital residency teaching programs will serve as the clinical faculty functioning as councils of chiefs in family practice, internal medicine, pediatrics, radiology, surgery, psychiatry, pathology, orthopedics, and obstetrics/gynecology.

The Basic Medical Sciences Facility for Phase II instruction is presently under construction at a geographically convenient site south of the intersection of Interstate 76 and State Route 44. Completion date is estimated for summer 1977.

The originally proposed six-year curriculum is continually undergoing refinement. Two classes of 42 students each are enrolled in Phase I university courses during Years 1 and 2 to fulfill 9 of the 12 academic quarter requirements necessary for the baccalaureate degree offered by the three consortium universities. The first class will begin Year 3 in 1977 at the Basic Medical Sciences Facility in Rootstown to fulfill the 12 academic quarters of the medical school portion of the curriculum by 1981.

(continued on page 634)

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3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

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Medical School Highlights *(continued)*

Year 4 will be hospital-based and dedicated to principles of ambulatory care as well as clerkships in pathology and radiology. In addition, mini-clerkships oriented towards the various body systems will be correlated with the ongoing program in the basic sciences. A weekly "Chart Review" conference will focus upon concepts in pathophysiology related to patients seen in the Family Practice Centers. Year 5 will consist of core clerkships in medicine, surgery, pediatrics, obstetrics/gynecology, and psychiatry. Year 6 will include courses relating to primary care, trauma, and the musculoskeletal system plus electives.

In Years 4, 5, and 6, the student will be required to return to the respective university campuses to study humanities, social sciences, and behavioral sciences to complete the remaining three academic quarters for the baccalaureate degree, an unusual feature of the curriculum.

A Letter of Reasonable Assurance was awarded to the College of Medicine by the Liaison Committee on Medical Education in April 1976. We look forward to the accreditation site visit for provisional accreditation in January of 1977 with action by the Liaison Committee in March 1977. It is anticipated that we will be permitted to admit students presently in Phase I into the medical portion of the curriculum, or Phase II, in September 1977.

Ohio State University College of Medicine

Henry G. Cramblett, M.D., Dean

The faculty of the College of Medicine at The Ohio State University strives to maintain a curriculum which is dynamic and relevant. As a result of continuous review of curriculum, minor cybernetic changes are made frequently and major revisions occur every few years.

Currently, the College of Medicine has a two-track, four-phased curriculum with patient-centered activities beginning in the first weeks of school. Time and sequence may be altered to fit individual goals of the medical students, and the medical school program may be completed in a minimum of 36 months. Each of the 233 medical students in a class may choose to spend additional time in order to fulfill personal goals.

In order to accommodate individual learning styles and to provide maximum flexibility in meeting the individual's education objectives, a two-track system has been developed in the first three phases. One track is the Lecture-Discussion Program and the other is the Independent Study Program. All students enter the same Phase IV Program.

Lecture-Discussion Track

Phase I, Introduction to Medicine, which operates concurrently with Phase II of the curriculum, is an

introduction to medicine in its broadest sense. The student is introduced to the professional problems in service to the patient and community, the delivery of health care, and the behavior and ethics of the physician by visits to practicing physicians' offices and community hospitals.

Phase II, the Study of Normal Man (six months), uses demonstrations and examinations of normal individuals and patients to promote an understanding of the nature of life processes, normal structure and function, behavior, and development. The study of the whole man is presented in a unified, patient-oriented, interdisciplinary manner. Studying the various aspects of normal life processes by means of history taking, physical examinations, and diagnostic techniques prepares the candidate for the subsequent study of the ill patient, disease entities, and the methods of treatment.

Phase III, Pathophysiology and Manifestation of Disease (nine months), is a multidisciplinary presentation of disease mechanisms, correlation of abnormalities of structure and function with cardinal symptoms, and manifestations of disease. A discussion of differential diagnosis of the most common patient complaints reinforces the concepts and mechanisms of disease processes.

The multidisciplinary approach to medical sciences in Phases II and III incorporates portions of anatomy, medical microbiology, pathology, pharmacology, physiological chemistry, and physiology of traditional programs.

Independent Study Track

The goals and curricular content of the Independent Study Program (ISP) are essentially the same as Phases I, II, and III of the Lecture-Discussion Program. However, topic sequence and learning methods differ significantly. In the ISP, each student proceeds at his own pace through a set of clinically oriented instructional modules, each of which he must master before proceeding. Faculty function as tutors in facilitating learning.

Throughout the curriculum, the student has available a computer-based method of self-evaluation which provides tutorial feedback. Clinical experiences are designed to demonstrate the relevance of the subject matter and to enhance student motivation.

Phase IV

In Phase IV (20 months) the medical student is given increasing opportunity to observe and to examine individual patients and to develop diagnostic and therapeutic skills taught by clinicians in the various disciplines. The candidate observes a great variety of clinical entities and participates as a member of the medical team that is responsible for the diagnosis and care of the patient in the facilities of the University Hospitals and affiliated hospitals of the College of Medicine. The student has ten months of required learning experiences in the clinical disciplines of medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery. There is a four-month experience in ambulatory-patient care and one month of community health services.

To encourage the candidate to pursue studies in the field of his greatest interest, advanced courses are available as electives which provide experiences in the medical sciences or the opportunity to undertake research problems.

A vacation period is provided during the last two weeks of December between Phases II and III. Multiple short breaks are provided in Phase III. One month of vacation may be elected in Phase IV. The first two weeks of June immediately prior to graduation are unassigned so that the candidate may prepare for his state or national qualifying examinations.

The curricular program was developed by the faculty to provide the maximum individualization of learning experiences for students in the community, outpatient clinics and inpatient hospital environments, and the laboratories. There are continuous opportunities for self-learning in the libraries, learning resource centers, and the Computer-Assisted Instruction Center.

Flexibility of planning and sequencing in the curriculum is possible. To facilitate accomplishment of individual goals, a faculty advisory program is available to the student.

University of Cincinnati College of Medicine

Robert S. Daniels, M.D., Dean

The University of Cincinnati College of Medicine is engaged in a major educational expansion from 120 students to 192 students in each class. This expansion

began in 1974 and will be completed in 1977. The College has moved into a new educational and research building which cost \$54 million. This building provides the basic space and support facilities for the expanded class. Included within the new building are a \$5 million library and superior educational support facilities.

Many of the curriculum and programmatic modifications are related to this class expansion. There has been attention to programmed learning, to the bio-behavioral sciences, to the setting of educational objectives, and to the diversification of sites for clinical education in multiple institutions. These associated institutions include Christ, Good Samaritan, and Jewish Hospitals in Cincinnati and the Georgetown (Ohio) Hospitals. New academic departments recently created include Family Medicine and Orthopaedic Surgery. Increased attention will be given to ambulatory-care education and to the training of personnel for primary health care.

The leadership for the Medical Center and the College has been very stable since World War II. Ten department directors have led their departments for more than 20 years. Now a number of these directors are at or near retirement age and if one takes a span of time between 1974 and 1979, there will be a new vice president and director of the medical center, a new dean, and 14 new department heads.

The University of Cincinnati College of Medicine is confronted with a remarkable opportunity with a relatively new hospital, a new medical college building, an expanded educational effort, new academic and administrative leadership, and entrance into the state system.
(continued on page 637)

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Medivest, Inc. is an Ohio investment advisory firm. The firm specializes in providing investment advisory information services designed to lower its clients' tax liabilities through investments in well-conceived and economically sound tax shelter programs, as well as information concerning venture projects that meet its stringent investment standards.

The Medivest, Inc. system, as a matter of policy, will not consider any venture project that cannot provide reasonably justifiable projections that will not show a better than 300-percent return in five years. Medivest, Inc. recognizes that the venture capital situation must offer, as an incentive, an opportunity to substantially increase the available return as compared to the type of relatively low-risk investment opportunity currently attracting the majority of investment capital.

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client's investment needs (rarely confined only to tax shelters), and obtaining his input concerning investment preferences. A projection of the current year's income tax projection is made, including an analysis of the present tax effects of previously purchased tax-shelter investments. Should the client not have a balance sheet, assistance is given for its preparation. Prior years' tax returns are also evaluated, and from this variety of information, a determination is made concerning the combination of investment vehicles that are appropriate to the clients' total needs.

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Medical School Highlights *(continued)*

tem of higher education (July 1977). These developments occur on a solid base of a sound medical college, the seventh oldest in the country, and strong community support.

Wright State University School of Medicine

John R. Beljan, M.D., Dean

For most physicians, receiving the medical degree marks the real beginning of the educational process—not the end. Most of us develop methods and patterns of continued education born out of necessity and often invented out of desperation. Modern philosophies of medical education embody the concept that education is a dynamic, continuous thing; it is ever-changing, ever-obsolescent, and ever-challenging. Today's medical schools have a responsibility to form an educational "union" with the community in which they exist to maximize local efforts at continuing education, to develop new approaches and new activities in partnership with the practicing community, and to use the vehicle of undergraduate medical education as a lever for continuing faculty education. In short, medical education is a continuum which exists from the entrance into medical school until death or retirement from active practice.

At the Wright State University School of Medicine, we have designed our Department of Postgraduate Medicine and Continuing Education (PMCE) to interweave lifelong learning opportunities for the practicing physicians of our area. PMCE was specifically organized as an academic department within the School of Medicine to insure its academic credibility and to develop appropriate collegial relationships with all of our clinical departments on a peer-level basis. Such a department must be identified as "faculty"—faculty-oriented, faculty-developed, and faculty-executed. In a decentralized, community-based medical education enterprise such as ours, with an active voluntary clinical faculty in excess of 500 members, such a definition is well-made and, even better, self-executed.

Our Department of Postgraduate Medicine and Continuing Education offers a variety of services to our medical community. The first of these is logistical. For example, if a medical organization in our area wishes to sponsor a specialized program, PMCE can provide a wide variety of consultant services dealing with educational processes, content, and evaluation, along with expertise in executing all necessary arrangements, from refreshments to refreshers. Through cooperative arrangements with directors of medical education in our affiliated institutions, a comprehensive metropolitan network of offerings can be coordinated and publicized.

The Department also initiates and develops educational programs for which specific needs have been demonstrated or uncovered. One of the Department's

early and very successful efforts was to design a series of forums and workshops aimed at faculty development of our voluntary clinical faculty. Three participatory workshops were developed to set educational objectives, discover methods of effective instruction, and evaluate educational effort. In addition, a series of forums on the Wright State University School of Medicine was developed for our entire faculty, both full-time and voluntary. These forums literally dissected the School of Medicine through a rigorous examination of our philosophy, objectives, organization, financing, building program, faculty structure, research, and admissions. These forums have helped our faculty members obtain insights and knowledge of a school of medicine unequalled anywhere in the country.

Finally, PMCE is now capable of tailoring programs to meet individual physicians needs, to literally follow the concept of a "university without walls." Our ultimate goal is to provide a wide variety of learning activities and educational experiences which are not only professionally challenging and stimulating to the medical community we serve, but which will also ultimately have an impact on health care delivery. As modern medical educators, we are obligated to provide high-quality medical education opportunities for our professional colleagues, both undergraduate and practicing. At the same time, we cannot overlook one of the major benefits of community-based educational programs: the opportunity for all of us to learn and to improve our own skills through close interaction with each other. This attitude is *the* prime objective of our Department of PMCE.

Have You Seen This Publication?



In the November issue of *Your Doctor Reports*, patients will read about why Britain's physicians are leaving to practice in other countries. They will also learn why the cost of U.S. health care has increased so dramatically in the last few years. Botulism in home-canned foods, stuffing the turkey at the time of cooking, and the effects of stress and emotional trauma on health are other topics covered in the November issue. Be sure that *Your Doctor Reports* appears in your waiting room.

obituaries

ROLLO W. BONNELL, M.D., Columbus; Ohio State University College of Medicine, 1928; age 73; died August 10; member OSMA and AMA.

WILLIAM R. BUSH, M.D., Canton; Case Western Reserve University School of Medicine, 1948; age 55; died August 23; member OSMA and AMA.

LELAND GEORGE COE, M.D., Canfield; Ohio State University College of Medicine, 1922; age 79; died August 16; member OSMA and AMA.

MORRISON W. EVERHARD, M.D., New Philadelphia; Case Western Reserve University School of Medicine, 1916; age 85; died August 11; member OSMA and AMA.

BLAINE GOLDSBERRY, M.D., Athens; Johns Hopkins University School of Medicine, Baltimore, 1918; age 83; died August 17; member OSMA and AMA.

JACK H. MOSTOW, M.D., Akron; Case Western Reserve University School of Medicine, 1955; age 46; died September 10; member OSMA and AMA.

SAMUEL PASTORELLE, M.D., Novelty; Ohio State University College of Medicine, 1933; age 68; died September 26; member OSMA and AMA.

WILLIAM T. PRESTON, M.D., Toledo; University of Louisville, 1937; age 66; died September 6.

BARBARA O. REMETHEY, M.D., Northfield; College of Medicine, University of the East, Quezon City, Philippines, 1961; age 65; died September 26.

RODNEY B. RICHARD, M.D., Worthington; Ohio State University College of Medicine, 1962; age 46; died September 19; member OSMA and AMA.

ERNEST N. SALOMON, M.D., Cleveland; University of Berlin, Prussia, Germany, 1913; age 91; died September 1976; member OSMA and AMA.

IRVING SCHILLING, M.D., Cincinnati; Eclectic College of Medicine, 1936; age 70; died September 4.

WILLIAM J. SLASOR, M.D., Massillon; Jefferson University, Philadelphia, 1936; age 64; died September 11; member OSMA and AMA.

LEE H. BROWN, M.D., Neenah, Wisconsin; Ohio State University College of Medicine, 1938; age 63; died September 20.

Librax® Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.





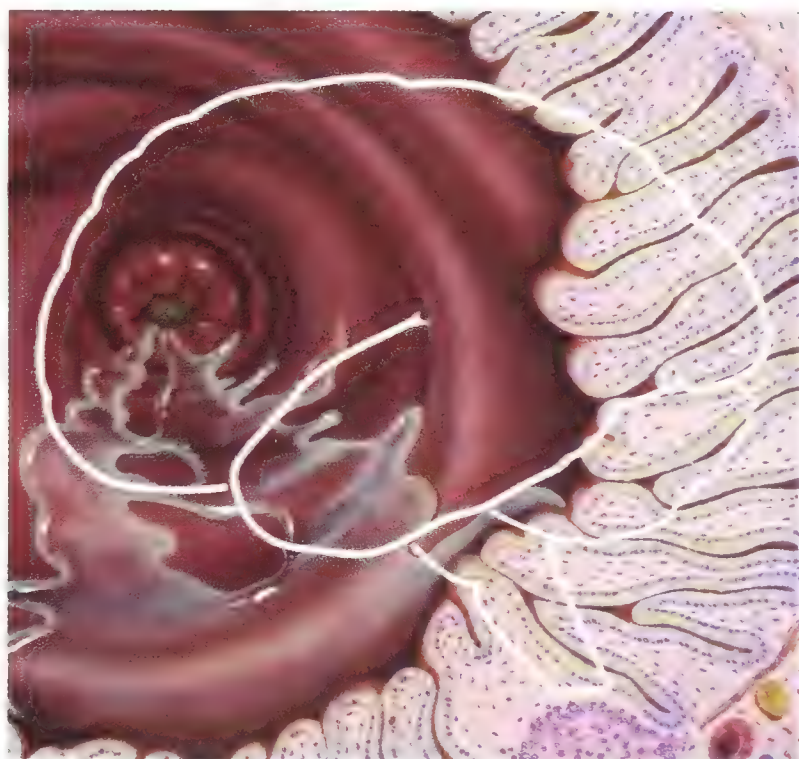
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OSMA Continuing Education Program

In September, the Council of the OSMA approved the establishment of the Department of Continuing Medical Education (CME) and appointed Mrs. Gail E. Dodson, formerly OSMA Convention Coordinator, Director of the Department. Douglas E. Houser was named Assistant Director. The OSMA Committee on Scientific Work, the Commission on Medical Education, and the Committee on Education will function within this Department.

OSMA Committee on Scientific Work

The Committee on Scientific Work will continue to handle the general arrangements for the Annual Meetings of the Association, including the scientific programs for both the general sessions and such sections as may be authorized by the OSMA Council and the scientific exhibits. In addition to the Annual Meeting, by virtue of being an *accredited* organization, the Committee will sponsor and cosponsor Category 1 CME programs for the OSMA membership not only at the Annual Meeting but throughout the year. In the past, the Committee has cosponsored programs with the Academy of Medicine of Cleveland, the Ohio Psychiatric Association, and the Ohio Thoracic Society, and plans to cosponsor a number of other programs in the future. In addition, a travel program entitled "Predictive and Preventive Medicine" was sponsored by the Committee on shipboard to Alaska. An article about this event appears in this issue of *The Journal*.

The Committee on Scientific Work encourages scientific sections, specialty societies, county medical societies, and other medical organizations to contact it for cosponsorship of high-quality Category 1 CME programs. The following policies on determination of which OSMA-sponsored or cosponsored activities will receive Category 1 credit were adopted by the OSMA Council and are reproduced for your use.

1. Requests for cosponsorship must be received a minimum of four months prior to the date of the activity.
2. Category 1 credit will be available to other organizations (through the OSMA accreditation) only if the Committee on Scientific Work assists the organizations in planning the CME activity.
3. The criteria for Category 1 shall be the same as that established by the AMA Council on Medical Education:
 - A. A planned program with specific educational objectives should be presented;
 - B. Syllabus or brief study outline, references, or tests are to be given to the participants;
 - C. The program should be evaluated by the sponsor;

- D. Physician participation must be planned; discussion time should be permitted in the program; and some assessment of needs should be made; and
 - E. Attendance must be taken.

4. The objectives for Category 1 credit shall be the same as that established by the AMA Council on Medical Education:

- A. Changes in the attitude and approach of the learner to the solution of medical problems,
 - B. Correction of outdated knowledge,
 - C. Explanation of new knowledge in specific areas,
 - D. The introduction to and/or mastery of specific skills and techniques, and
 - E. Alteration in the habits of the learner.

Category I Accreditation

The Commission on Medical Education's prime responsibility is to *accredit* hospitals, institutions, and organizations so that they can provide CME activities which qualify for Category 1 credit. Accreditation is official recognition by the Ohio State Medical Association and the AMA Council on Medical Education that an organization's overall program of CME for physicians is of high quality. Broadly speaking, the AMA accredits medical schools and other organizations serving physicians from several states. **OSMA accredits intrastate hospitals and organizations/institutions.**

There is no difference between AMA and OSMA accreditation since the OSMA operates under the authority of the AMA Council on Medical Education and its Advisory Committee on CME. Accreditation by the OSMA is equivalent to action by the AMA.

Accreditation of an organization is important in at least two ways. First, the process of gaining accreditation provides an opportunity for review of the quality of continuing medical education (CME) activities. This review should be an incentive to make changes and/or improvements in the programs as may be indicated by the organization or survey team. Second and most important to the individual physician, the Physician's Recognition Award (PRA) is based on a three-year cycle. In order to qualify for the award, 150 credit hours of CME must be accumulated within a three-year period, of which 60 hours must be in Category 1.

Concept of Planned Program

Category 1 programs must meet the criteria of a planned program. A planned program of CME is one having sufficient scope and depth of coverage of a subject area or theme to form an educational unit. This

unit should be planned, coordinated, administered, and evaluated in terms of educational objectives that give a defined level of knowledge or a specific performance skill to be attained by the physician participating in the program.

The concept of a planned program of CME involves the organized presentation of a body of knowledge so that the subject is comprehensively covered in sufficient detail to meet the educational objectives. As an example, a planned program involving a clinical subject might include a review of its basic science aspects, as well as details of the diagnosis, management, and aftercare. By using appropriate objectives, very narrow or highly specific CME programs can be developed so they meet the definition of a planned program of CME. A series of unrelated lectures dealing with different topics and covering only one or two points of each topic would not be a planned program of CME.

To the extent possible, educational objectives should be based upon CME needs. Where group or individual CME needs cannot be based on a practice profile, peer review, self-assessment, case audits, and so forth, newly developed medical knowledge is often used as a basis for developing the educational objectives that are specific for a knowledge level or performance capability.

Presentation of problem cases with "give and take" conversation can lead to an air of informality, as will question-and-answer periods or small group workshops for a part of the time. When technical data are being presented, the lecturer may stop from time to time to ask if his material is clear, if there are any questions, or if anything should be repeated. Provocative discussion questions may be prepared.

The course syllabus is a requirement for a Category 1 program, and a course syllabus should be available to each registrant. Experience has shown that in most instances a course syllabus can be an effective aid in the learning experience. The syllabus should contain:

- (A) The objectives of the course;
- (B) Names, addresses, and titles of faculty members;
- (C) An adequate abstract or outline of each presentation with summary or case histories, if appropriate;
- (D) Reproductions of essential slides or salient features of each slide (instead of using slides which are easily forgotten, place the information in the syllabus, if appropriate);
- (E) A bibliography from each instructor, listing three or four of the most important references; and
- (F) A glossary of important terms and abbreviations when needed.

Category I Activity Sponsors

The following organizations in Ohio are accredited to sponsor or cosponsor Category 1 continuing medical education activities:

OSMA, Committee on Scientific Work, Columbus.

AKRON: Akron City Hospital, Saint Thomas Hospital

CHILLICOTHE: Veterans Administration Hospital

CINCINNATI: Good Samaritan Hospital, University of Cincinnati College of Medicine

CLEVELAND: American Broncho-Esophagological Association, Case Western Reserve University School of Medicine, Cleveland Clinic Educa-

(continued on page 645)



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Narrowing down pneumonias

Upjohn

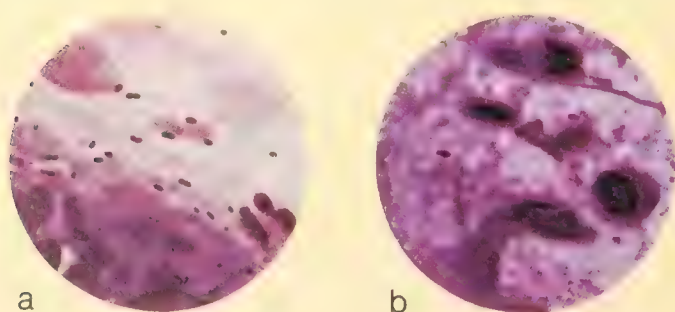
Bacterial or nonbacterial?

In the early stages of mild to moderate pneumonia, it is often difficult to reach an accurate bacteriologic diagnosis. A tentative differentiation may be made on history-taking, physical examination, CBC with differential analysis, and microscopic study of the sputum smear. Specimens should be obtained for culture and sensitivity testing, but when a bacterial pneumonia is diagnosed, therapy is often instituted before the etiological agent is positively identified.

Bacterial pneumonias may have a sudden onset with a shaking chill, rapid development of fever, pleuritic pain, and cough productive of rust-colored sputum. The Gram-stained sputum smear generally shows polymorphonuclear neutrophils as well as a predominance of the causative organisms. These are likely to be *Streptococcus pneumoniae*, still by far the most frequently encountered agent in bacterial pneumonia.¹ The CBC reveals marked leukocytosis with a shift to the left.

In *nonbacterial pneumonias*—mycoplasmal or viral—classical symptoms tend to develop more slowly, with myalgia, lassitude, and headache predominating. Sputum production is usually scanty, and the sputum smear is relatively uninformative, showing gram-positive cocci and other organisms which are part of the normal pharyngeal flora. The leukocyte count is normal or slightly elevated.

Direct Gram-stained sputum smears. (a) Pneumococcal pneumonia—note abundant polymorphonuclear leukocytes, as well as gram-positive diplococci. (b) Nonspecific—consistent with viral or mycoplasmal pneumonia. Note large mononuclear cell, as well as a few polymorphs and mixed bacterial flora (pharyngeal contaminants).



a

b

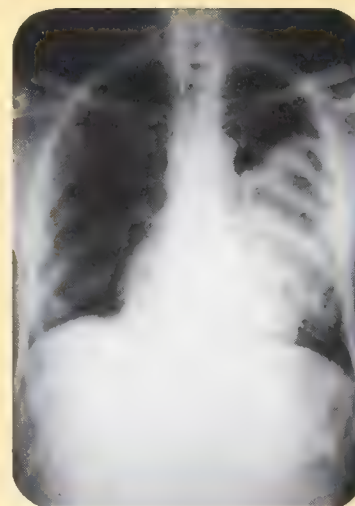


Mycoplasmal or viral?

Differentiation between mycoplasmal and viral pneumonias may be impossible in the acute stage.²

Serologic testing and culture methods for *Mycoplasma pneumoniae* are complex and time-consuming, taking as long as two weeks after obtaining samples. The sensitivity and specificity of the test for cold agglutinins have been questioned. The complement-fixing antibody test may reflect previous infection. Furthermore, facilities for culturing *M. pneumoniae* are not widely available.³

If treatment is to be initiated, therefore, it may be necessary to start on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.¹⁻³ In reaching such a diagnosis, the physician relies on clinical judgment, considering such factors as the age of the patient and the history of exposure. For example, *Mycoplasma pneumoniae* is considered the most common cause of pneumonia among ambulatory patients aged 20 to 35.¹

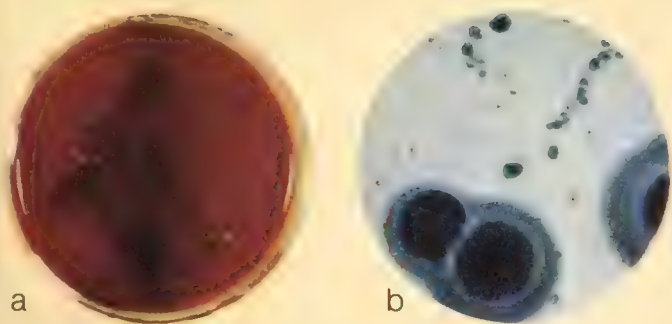


a



b

Chest x-rays of patients with (a) pneumococcal pneumonia—classically heavy, extensive infiltration of left lung; (b) mycoplasmal pneumonia—mild infiltrate confined to left lower lobe. Roentgenography usually does not help in differential diagnosis, since both types of pneumonias may present with a wide spectrum of x-ray as well as clinical findings.



(a) Distinct mucoid colonies of type 3 pneumococci (*Streptococcus pneumoniae*) on sheep blood agar showing greenish discoloration (alpha-hemolysis) of medium. (b) Typical "fried-egg" colonies of *Mycoplasma pneumoniae* consisting of dense central core with lighter periphery. Cultural and serologic methods for detecting *M. pneumoniae* are complex, time-consuming, and not widely available.

Expectant therapy

the patient with a presumptive diagnosis of mycoplasmal pneumonia or bacterial pneumonia, it may be desirable to initiate antibiotic therapy before culture and sensitivity results are available.

A course of erythromycin or tetracycline is considered effective in the treatment of mycoplasmal pneumonia to help speed the clearing of infiltrate and shorten the duration of symptoms.^{1,3} In pneumococcal pneumonia, erythromycin is an effective alternative to penicillin, the drug of choice. A recent report, based on data from 200 hospitals of 100 beds or more, found 83% of *S. pneumoniae* sensitive *in vitro* to erythromycin.⁴

Among these therapeutic agents, only erythromycin provides effective coverage of both *Mycoplasma pneumoniae* and *S. pneumoniae*. The penicillins are not effective against *Mycoplasma*, and *S. pneumoniae* has shown a relatively high incidence of resistance to tetracycline.

When erythromycin is selected for therapy, E-Mycin (erythromycin enteric-coated tablets, Upjohn) is a good choice. E-Mycin is administered and absorbed as active erythromycin base, and may be taken q.i.d., q 6h, or b.i.d., immediately after meals or between meals. Thus, patients can use mealtimes to help them remember their medication. The enteric coating on E-Mycin tablets helps ensure efficient absorption in the intestinal tract, and bioavailability studies show that E-Mycin can be expected to produce predictable, acceptable blood levels. The low cost of E-Mycin helps assure economical therapy.

E-Mycin rarely causes serious side effects and is not associated with liver toxicity.* The most frequent side effects are upper gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. Serious allergic reactions, including anaphylaxis, have rarely been reported.

Use cautiously in patients with severe liver impairment

REFERENCES: 1. Chusid EL, Dairymple W, Holloway WJ, et al: Managing the infectious pneumonias. *Patient Care* 9:122-167, 1975. 2. The occasional might of mycoplasma. *Emergency Med* 7:82, 85, 1975. 3. Stevens DA: Viral and Mycoplasma pneumonias. *Postgrad Med* 55:81-86, 1974. 4. Data source: PMR Bacteriologic Report, Winter Series

Summary

Because pneumonias may be difficult to differentiate at the outset, treatment is often initiated before a causal diagnosis is made. However, readily available diagnostic criteria occasionally allow early differentiation between bacterial and nonbacterial pneumonias. When the diagnosis appears to be nonbacterial pneumonia, further differentiation between mycoplasmal pneumonia and viral pneumonia is more complex and time-consuming. Therefore, therapy is often initiated on the basis of a presumptive diagnosis of mycoplasmal pneumonia.

Erythromycin is an effective antibiotic against *Mycoplasma pneumoniae*, *Streptococcus pneumoniae*,† and *Streptococcus pyogenes*.† E-Mycin (erythromycin enteric-coated tablets, Upjohn) is administered and well absorbed as the active base, may be taken immediately after meals or between meals, and is essentially nontoxic.

†Although penicillin remains the drug of choice against these organisms, erythromycin is an effective alternative



E-Mycin® 250 mg

erythromycin enteric-coated tablets, Upjohn

wide-ranging usefulness in pneumonia*

*Mild to moderately severe, due to susceptible organisms

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1975-1976. Data are a compilation of laboratory reports submitted during December 1975 and January and February 1976 by 200 acute care hospitals of 100 beds or more.

Please turn page for brief summary of prescribing information.

Narrowing down pneumonias

Upjohn

Bacterial or nonbacterial?

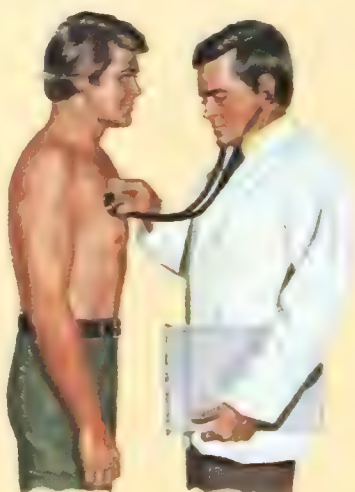
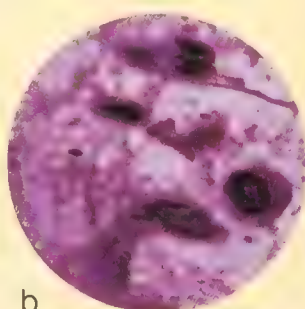
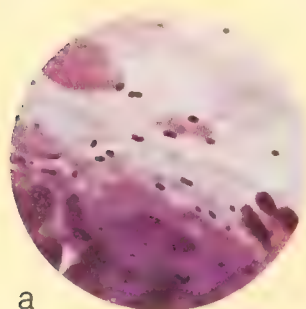
In the early stages of mild to moderate pneumonia, it is often difficult to reach an accurate bacteriologic diagnosis. A tentative differentiation may be made on history-taking, physical examination, CBC with differential analysis, and microscopic study of the sputum smear.

Specimens should be obtained for culture and sensitivity testing, but when a bacterial pneumonia is diagnosed, therapy is often instituted before the etiological agent is positively identified.

Bacterial pneumonias may have a sudden onset with a shaking chill, rapid development of fever, pleuritic pain, and cough productive of rust-colored sputum. The Gram-stained sputum smear generally shows polymorphonuclear neutrophils as well as a predominance of the causative organisms. These are likely to be *Streptococcus pneumoniae*, still by far the most frequently encountered agent in bacterial pneumonia.¹ The CBC reveals marked leukocytosis with a shift to the left.

In *nonbacterial pneumonias*—mycoplasmal or viral—classical symptoms tend to develop more slowly, with myalgia, lassitude, and headache predominating. Sputum production is usually scanty, and the sputum smear is relatively uninformative, showing gram-positive cocci and other organisms which are part of the normal pharyngeal flora. The leukocyte count is normal or slightly elevated.

Direct Gram-stained sputum smears. (a) Pneumococcal pneumonia—note abundant polymorphonuclear leukocytes, as well as gram-positive diplococci. (b) Nonspecific—consistent with viral or mycoplasmal pneumonia. Note large mononuclear cell, as well as a few polymorphs and mixed bacterial flora (pharyngeal contaminants).

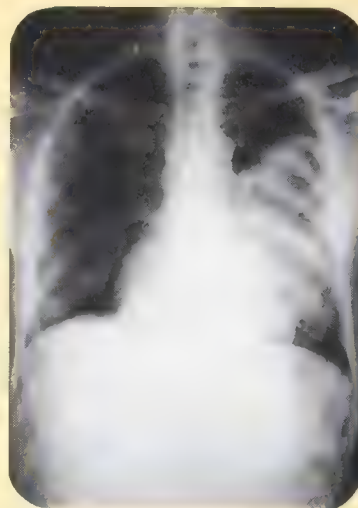


Mycoplasmal or viral?

Differentiation between mycoplasmal and viral pneumonias may be impossible in the acute stage.

Serologic testing and culture methods for *Mycoplasma pneumoniae* are complex and time-consuming, taking as long as two weeks after obtaining samples. The sensitivity and specificity of the test for cold agglutinins have been questioned. The complement-fixing antibody test may reflect previous infection. Furthermore, facilities for culturing *M. pneumoniae* are not widely available.³

If treatment is to be initiated, therefore, it may be necessary to start on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.¹⁻³ In reaching such a diagnosis, the physician relies on clinical judgment, considering such factors as the age of the patient and the history of exposure. For example, *Mycoplasma pneumoniae* is considered the most common cause of pneumonia among ambulatory patients aged 20 to 35.¹

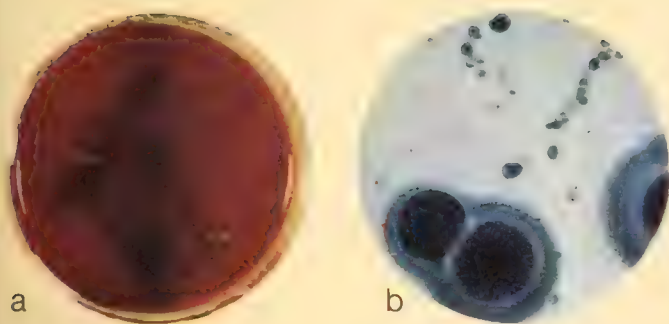


a



b

Chest x-rays of patients with (a) pneumococcal pneumonia—classically heavy, extensive infiltration of left lung; (b) mycoplasmal pneumonia—mild infiltrate confined to left lower lobe. Roentgenography usually does not help in differential diagnosis, since both types of pneumonias may present with a wide spectrum of x-ray as well as clinical findings.



(a) Distinct mucoid colonies of type 3 pneumococci (*Streptococcus pneumoniae*) on sheep blood agar showing greenish discoloration (alpha-hemolysis) of medium. (b) Typical "fried-egg" colonies of *Mycoplasma pneumoniae* consisting of dense central core with lighter periphery. Cultural and serologic methods for detecting *M. pneumoniae* are complex, time-consuming, and not widely available.

Expectant therapy

In the patient with a presumptive diagnosis of mycoplasmal pneumonia or bacterial pneumonia, it may be desirable to initiate antibiotic therapy before culture and sensitivity results are available.

A course of erythromycin or tetracycline is considered effective in the treatment of mycoplasmal pneumonia to help speed the clearing of infiltrate and shorten the duration of symptoms.^{1,3} In pneumococcal pneumonia, erythromycin is an effective alternative to penicillin, the drug of choice. A recent report, based on data from 200 hospitals of 100 beds or more, found 98% of *S. pneumoniae* sensitive *in vitro* to erythromycin.⁴

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*Use cautiously in patients with severe liver impairment

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Summary

Because pneumonias may be difficult to differentiate at the outset, treatment is often initiated before a causal diagnosis is made. However, readily available diagnostic criteria occasionally allow early differentiation between bacterial and nonbacterial pneumonias. When the diagnosis appears to be nonbacterial pneumonia, further differentiation between mycoplasmal pneumonia and viral pneumonia is more complex and time-consuming. Therefore, therapy is often initiated on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.

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[†] Although penicillin remains the drug of choice against these organisms, erythromycin is an effective alternative.



E-Mycin® 250 mg
erythromycin enteric-coated
tablets, Upjohn

**wide-ranging usefulness
in pneumonia***

*Mild to moderately severe, due to susceptible organisms

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1975-1976. Data are a compilation of laboratory reports submitted during December 1975 and January and February 1976 by 200 acute care hospitals of 100 beds or more

Please turn page for brief summary of prescribing information.

Wide-ranging usefulness in pneumonia*

E-Mycin® 250 mg
erythromycin enteric-coated
tablets, Upjohn

Upjohn

- For mild to moderately severe infections due to susceptible organisms that commonly invade the respiratory tract
- Essentially nontoxic (see Precautions and Adverse Reactions below)
- Documented bioavailability
- May be taken immediately after meals or between meals
- Active base formula produces predictable blood levels
- Formulated for quality...priced for economy

E-MYCIN® TABLETS — 250 mg — For Oral Administration (erythromycin enteric-coated tablets, Upjohn)

E-Mycin Tablets are specially coated to protect the contents from the inactivating effects of gastric acidity and to permit efficient absorption when administered either immediately after meals or when given between meals on an empty stomach.

Indications: *Streptococcus pyogenes* (group A beta-hemolytic streptococci): Upper and lower respiratory tract, skin, and soft-tissue infections of mild to moderate severity. Parenteral benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever. When oral medication is necessary (because the parenteral route is contraindicated) or if there is known allergy to penicillin, the following recommendations made by the American Heart Association apply: 1) Oral penicillin G or V (where no allergy exists)—This is the drug of choice. Give for a minimum of 10 days; 2) Erythromycin—Give for a minimum of 10 days. A few strains of streptococci resistant to erythromycin have been reported.

Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.)
Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.

Diplococcus pneumoniae: Upper respiratory tract infections (eg, otitis media, pharyngitis) and lower respiratory tract infections (eg, pneumonia) of mild to moderate degree.

Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.

Treponema pallidum: Infections due to this organism.

Corynebacterium diphtheriae and *Corynebacterium minutissimum*: As an adjunct to antitoxin, to prevent establishment of

carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents.

Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdosage: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdosage should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.

How supplied: 250 mg enteric-coated tablets—in bottles of 100 and 500 tablets, and in unit-dose packages of 100 tablets. Caution: Federal law prohibits dispensing without prescription.

For additional product information, consult the package insert or see your Upjohn Representative.

NAS-4

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*Mild to moderately severe, due to susceptible organisms

OSMA Education Program *(continued)*

tion Foundation, International Anesthesia Research Society, Nuclear Medicine Institute, Ohio Valley Society for Plastic and Reconstructive Surgery

COLUMBUS: Mount Carmel Hospital, Ohio Academy of Family Physicians, Ohio State University College of Medicine, Center for Continuing Medical Education, Riverside Methodist Hospital

DAYTON: Miami Valley Hospital, Wright-Patterson Air Force Base Medical Center

KETTERING: Kettering Medical Center

MARION: Community Medical Center Hospital

MARYSVILLE: Memorial Hospital of Union County

NEWARK: Licking Memorial Hospital

SPRINGFIELD: Mercy Medical Center

TOLEDO: Medical College of Ohio

WILLOUGHBY HILLS: American Electroencephalographic Society

XENIA: Greene Memorial Hospital

YOUNGSTOWN: Mahoning Shenango Area Health Education Network

If your organization is interested in becoming recognized as an accredited organization, please contact the Commission on Medical Education for further instructions on procedure.

150 Hours Continuing Education Necessary for Relicensure in 1980

CME has always been an important facet of medicine. However, since the physician must document 150 hours of CME obtained between January 1, 1977 and December 31, 1979 as a condition for reregistration of medical license in 1980, it has become even more important. Procedures that must be completed for a certificate of triennial reregistration with the Ohio State Medical Board are being developed, and a complete report of the protocol will be published in *The Journal* as soon as it is available. But without question, every Ohio physician should begin planning now on achieving 150 hours of high-quality CME in the next three years. In this manner, he will be prepared for reregistration of his medical license in 1980.

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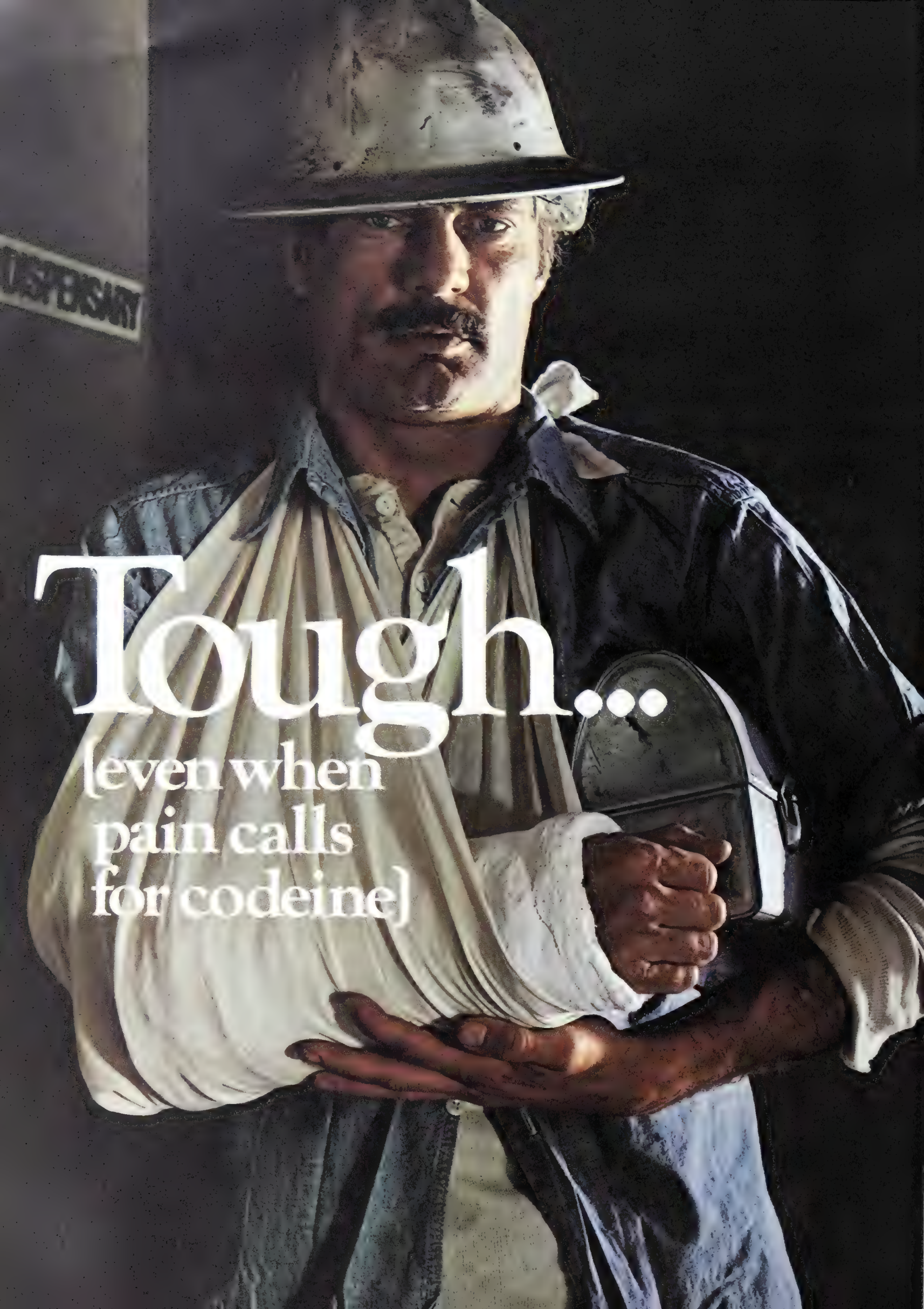
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CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950
A. C. Spath, Jr., R. A. Zimmerman

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: Suite 221, 5241 Southwyck Blvd., (419) 865-5215, R. E. Stallter



Tough...

(even when
pain calls
for codeine)

but he may not have the stomach for APC.

Or the kidneys, for that matter.

Even bleeding time and platelet aggregation can be maximally prolonged by a single aspirin tablet.*

We took that into account in revising the formula of Phenaphen[®] with Codeine, and combined codeine (in any of three different strengths) with acetaminophen to complement the codeine with little risk of APC complications. While there's no anti-inflammatory activity, there's no aspirin to aggravate G.I. problems or adversely affect bleeding time. Similarly, there's no potential renal risk from phenacetin, and no caffeine to stimulate patients unnecessarily.

There is the convenience of telephone Rx under Federal law...and the complementary analgesic efficacy of acetaminophen.

Phenaphen[®] with Codeine. Not just for patients who might have a "compound" problem, but for almost every patient who needs codeine. It's a lot simpler than APC.

BRIEF SUMMARY

Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act

Usage in ambulatory patients. Caution patients that acetaminophen and codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings

For symptoms and treatment of overdosage and full prescribing information, see package insert.



**Phenaphen[®]
with Codeine
No.3[®]**

Codeine Phosphate, USP-30 mg
(Warning: May be habit forming)
Acetaminophen, USP - 325 mg

**to complement
codeine with
little risk of APC
complications**

*Mielke, C.H., et al.: JAMA
235 613 (Feb. 9) 1976

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Richmond, Va. 23220

OSMA Sponsors Unusual Courses

Category I Trip to Alaska

During August, the OSMA sponsored the first Category I continuing medical education (CME) tour. "Predictive and Preventive Medicine" was the topic for the seminar held during a week-long air-sea trip to Alaska. Course Director was Jack R. Kirschner, M.D., Senior Attending Physician at Cincinnati's Jewish Hospital and Assistant Clinical Professor at the University of Cincinnati College of Medicine. Course Moderator was Jerry L. Hammon, M.D., Admissions Staff Physician at the Veterans Administration Center, Dayton, and Assistant Clinical Professor in the Department of Family Practice at Wright State University School of Medicine.

Thirty-six Ohio physicians, representing 13 medical disciplines, participated in this program for which they earned nine credit hours in Category I. The course covered the important aspects of searching out predictive and preventive disorders by periodic health examinations including an understanding of risk factor analysis, history taking, physical examination, and ancillary studies.

Course instruction took place while the tour was at sea and, as such, did not interfere with any in-port activities. The times were also coordinated with all major shipboard functions so that the course participants could avail themselves of most ship activities.

Physician reaction to this type of Category I CME activity was excellent. Participants felt that the combination of education and pleasure was most beneficial as it satisfied both professional growth and relaxation. OSMA anticipates another CME trip in the future.

Practice Management Workshop Draws the Young Physician

A two-day workshop for young physicians planning to enter private practice was held on September 14 and

15 at the OSMA Headquarters Office. The workshop was cosponsored by the OSMA and the AMA.

Twenty physicians and three guests in the management field attended the workshop which covered personnel problems, patient flow techniques, physical aspects of the medical office, paperwork—clinical, paperwork—financial, socio-economic aspects of medical practice, location of practice, and legal problems. The workshop instructors were professional management consultants with a thorough understanding of the many problems of establishing a medical practice. To further enhance the program, extensive reference materials were provided including a comprehensive workbook that could be used later as an office manual.

Those in attendance rated the workshop as excellent and suggested that at least one workshop of this nature be conducted by the OSMA each year. Arrangements are underway for another workshop on April 12 and 13, 1977. Watch *The Journal* and the *OSMAgram* for announcements of the second OSMA program on "Establishing Yourself in Medical Practice."

The following physicians were registered: Somwang Apichairuk, M.D., Akron; Gerald A. Cickocki, M.D., Toledo; Nepomuceno Z. Dario, Jr., M.D., Wheeling, West Virginia; Richard L. Fawcett, M.D., Akron; Alice A. Frazier, M.D., Westerville; David I. Freidman, M.D., Sylvania; Bruce Greenberg, M.D., Cincinnati; David L. Kahn, M.D., Great Lakes, Illinois; Christopher Kircher, M.D., Cincinnati; Gregory Kundrat, M.D., Columbus; Antonio Lauengco, M.D., Toledo; Ronald D. Roberts, M.D., Cincinnati; Jonathan Rohrs, M.D., Toledo; Arturo T. Santos, M.D., Wheeling, West Virginia; C. T. Stafford, M.D., East Cleveland; Stuart Steinberg, M.D., Cincinnati; William T. Twell, Jr., M.D., Columbus; John Vela, M.D., Toledo; R. K. vonMaur, M.D., Portage, Michigan; and Robert L. Westerheide, M.D., Mt. Vernon.



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of Psychiatric Disorders**

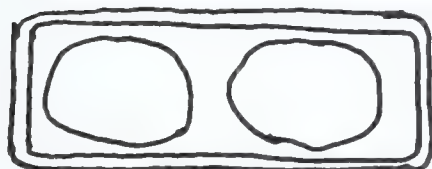
High on a Hill-Top, Overlooking Beautiful
Chagrin River Valley.

Booklet available on request.

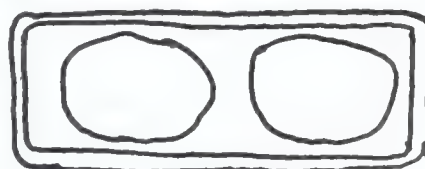
HERBERT A. SIHLER Jr.
President

Leasing your new car can make good business sense.

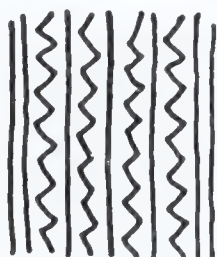
Right now, many business and professional people are considering buying a new car. But before you put down a penny of down payment, consider leasing instead. There are several sound financial reasons that favor leasing—possible tax advantages or the cash flow aspects, for example. Your accountant or tax advisor can evaluate how leasing can affect your individual financial picture. We can offer you two choices: purchase financing or, in cooperation with a group of area auto dealers, lease financing. It will only take a few moments of your time to determine whether leasing a car would be good business for you. If it is, we can help you



apply to lease from a participating dealer, almost any make, model and color new car you'd like, with any optional equipment you'd like.



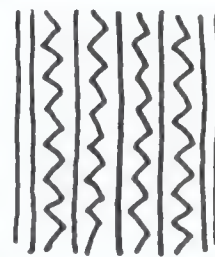
So, if you're in the market for a new car, be it lease or purchase, come in and see us. We are here to help with your financial requirements.



It's worth the talk.

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1975 Recipients

(Editor's Note: All physicians who qualify for the OSMA Physician's Recognition Award have achieved 150 hours of continuing medical education during a specified three-year period. For example, the 1976 Physician's Recognition Award is based on credit hours earned between January 1, 1974 and December 31, 1976. Each of the following physicians, who have to date received the award, is to be commended for his desire for professional growth through continued education.)

ASHLAND

H. Wayne Smith

ASHTABULA

G. K. Jones
William McCarthy

AUGLAIZE

Barbara J. Cummins

BELMONT

Lois R. Zimmerman

BUTLER

S. Alatorre
Louis Luke Barich
Robert P. Carson
Clyde G. Chamberlin
John H. Hanekamp
Ann H. Oyer

CLARK

Sally Abbott

COLUMBIANA

Virgil C. Hart

CUYAHOGA

Felix Arakaki
Saul P. Baker
Steven M. Klein
Charles Long
R. G. Norby
Madhira Dasarakh Ram
John G. Sholl
Philip R. Suresky

DARKE

Jesse L. Heise

ERIE

Wing-Cheong Chau

FAIRFIELD

A. C. Essman

FAYETTE

Hugh W. Payton

FRANKLIN

Irving Pine

GEAUGA

Hertha F. Binder
Rudolf F. Binder

GREENE

Ray W. Barry
Jeffrey B. Blackburn
Priyakant K. Desai

HAMILTON

F. X. Lowell Baurichter
Robert C. Burt
William Dobur
John G. Fleming
Domenic J. Foglia
William H. Gates
Rae E. Hartman
Max Krakauer
Alfred Lustberg
James A. Quinn, Jr.
Bertold J. Pembaur

HANCOCK

John M. Mertus

HIGHLAND

Walter Felson

HOCKING

L. W. Starr

HURON

Paul E. Burson
Harold D. Erlenbach

LAKE

Bruce F. Andreas

LAWRENCE

Carl H. Laestar

LICKING

Ralph E. Pickett
Charles F. Sinsabaugh

LORAIN

Alvin L. Berman
I. N. Eren

LUCAS

Walter Chilmonezyk
E. A. Espinosa
Carl P. Herkimer
William A. Sodeman

MAHONING

Hyon S. Hwang
David H. Levy

MEDINA

Hilaire Gaudreault

MIAMI

Marcus Miller

MONTGOMERY

Y. Joe Kwon

PORTAGE

Suleyman Sami Solu

SANDUSKY

Richard R. Wilson

SCIOTO

Chester H. Allen

STARK

Andreas S. Ahbel
John J. Dobkins
William S. Rothermel

SUMMIT

Robert E. Thompson

TRUMBULL

Edward E. Bauman
Irvine G. Milheim
Richard D. Shapiro

UNION

Walter R. Burt

WILLIAMS

Naranbhai L. Patel

1976 Recipients

ALLEN

T. D. Allison
Hector A. Buch
Francisco J. Vidal
Gene E. Wright
Carl H. Zinsmeister

ASHLAND

Henry C. Chalfant
K. C. Krishnamurthi

BELMONT

Chaganlal N. Patel
Theron R. Rolston
J. F. Sutherland

BROWN

Vytautas Karoblis

BUTLER

Pacifico C. Amaro
James M. Anderson
Robert P. Carson
John M. Evans
Arnold Gross
Charles W. Patterson

CARROLL

Jack L. Maffett

CHAMPAIGN

Terrence F. Grogan

CLARK

Robert B. Beam
Sidney J. Glueck

COLUMBIANA

Robert M. Dunlap
H. F. Hoprich
William A. Kolozsi
L. S. Pritchard
Manolo P. Mapa

CUYAHOGA

Isidro J. Amigo
William R. Bauer
James E. Bennett
Robert B. Benyo
Webb Chamberlain
William B. Chamberlin, Jr.
Chun K. Chung
William G. Gilger
Norbert S. Gizinski
Milton B. Good
Hershel Goren

Cleora K. Handel
Morris I. Heller
Robert E. Hermann
Mario D. Kamionkowski
Philip Kazdan
Philip A. Khairallah
Naguib T. Khalil
Sutek Lie
Alexander Ling
Hubert F. Loyke
Lyle Moses
Harry Sherman
Bruce H. Stewart
Donald F. Weegar
Myron J. Welty

DARKE

Daryl M. Parker
Gregory M. Weber

DEFIANCE

Benedict B. Lenhart

DELAWARE

A. R. Callander

FAIRFIELD

Anna M. Whetstone
Paul M. Whetstone

FRANKLIN

L. Eugene Arnold
Janet K. Bixel
Richard B. Butler
Richard D. Carr
Feliciano G. Dolor
Hobart R. Helman
Melanie S. Kennedy
Albert Kostoff
Robert Levine
Ernest S. Melaragno
Irving Pine
Alan G. Resor
A. Ruppertsberg, Jr.
Augusto A. Santos

GALLIA

Reid C. Brubaker

GEAUGA

S. Hayashi

GREENE

Richard A. Falls
Justin G. Krause
Sajjad-Ul-Haq-Siddiqi
R. David Warner

GUERNSEY

Earl E. Conaway

HAMILTON

Alan B. Ashare
Arthur O. Bachman
Robert H. Chess
Donald K. Ebersold
Archie Fine
Karl F. Finnen
Eugene P. Fromm
John H. Hanekamp
Donald K. Hawley
Harold Hiatt
Leon Hirsh
R. B. Homan
H. B. Howes
Robert A. Kemper
David M. Kerman
Abraham A. Kerr
Vincent H. Linz
Max L. Lurie
James M. Marrs
William P. Mulvaney
Chester E. Nameth
Lucy O. Oxley
Marvin Pravda
Walter L. Pritz
Albert Sapadin
Carl J. Schmidt
Abbot G. Spaulding
Donald R. Thomas
Thomas U. Todd
Frank Von Holle
Bahram Ziaie

HANCOCK

Samuel W. Fink
William Kose

HARDIN

Leonard K. Smith

JEFFERSON

Crist G. Strovilas

KNOX

James C. McLarnan

LAWRENCE

John A. Mayer

LICKING

Leroy B. Bloomberg
R. Gilbert Mannino
George Morrice

(continued on page 654)



RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
MAC rules**

**Drug
Substitution**

**The Common Denominator
of Health Progress**
RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

OSMA Physician's Recognition Award Recipients

LICKING (continued)

William H. Overholser
Arthur J. Tronstein
John J. Winsch

LORAIN

H. David Sacks
Rudolph A. Styblo

LUCAS

William S. Blakemore
Homer A. Caruso
John W. Erkert
A. R. Fuhlbrigge
B. Leslie Huffman, Jr.
Rolland E. Scherbarth
L. W. Siberd
Daniel S. Wolff

MADISON

William T. Bacon

MAHONING

G. J. Baumblatt
Emil Constantinidi
Sidney C. Keyes
C. M. Kohli
David H. Levy
Nora S. Natividad
Asher Randell
Lewis Shensa

MARION

Tsongsheng Chen
Mahumuni Ganesan

MEDINA

Irene M. Leszkiewicz

MONTGOMERY

Raymond K. Bartholomew
David E. Brown, Jr.
Howard W. Heywood
Raymond M. Kahn
Louis J. Kerth
Joseph J. Larkin
Hassan Mehbood
James W. Morris
James A. Rodeghero
Luis I. Rodriguez-Baz
Robert E. Sooy

MORGAN

James W. Caton

MORROW

William S. Deffinger

MUSKINGUM

John W. Ray

PICKAWAY

F. W. Anderson
C. R. Hedges

PREBLE

J. R. Williams

PORTAGE

David S. Palmstrom

RICHLAND

Thomas H. Croghan
Alvaro Gonzalez
Rockn Jalili
William E. Schamadan

ROSS

Lewis W. Coppel
Robert P. Giesler
Paul F. MacCarter, Jr.
George Howard Wood

SANDUSKY

Robert C. Fox

SCIOTO

Mitchel C. Newman
J. R. Sheets

SENECA

Walter A. Daniel
Hashem Moosavi Far

STARK

Richard W. Belcher
John D. Botti
Jerome D. Fladen
S. W. Gregory
G. R. Sicard
Felipe J. Vilar

SUMMIT

Massood Reza Babai
Ramon V. Banez
John A. Campbell
Charles E. Casto
Thomas J. Jackson
Marvin S. Platt
Timothy B. Rice
Edwin A. Riemenschneider
John A. Soquel

TRUMBULL

Luis E. Cali
Amanto P. D'Amore
Bohdan O. Fecowycz
Richard W. Juvancic
J. J. LaPolla
P. K. Soleimani

UNION

R. B. Hurl

WARREN

Thomas E. Fox
Gilbert K. Ohlhauser

WAYNE

Ira Hinden
Arun K. Mathur
Richard W. Reiman
John M. Robinson
Eric W. Walter

WILLIAMS

Virgil N. Carrico



Donald J. Vincent, M.D., Director of Medical Education at Riverside Methodist Hospital, Columbus, presents Richard L. Fulton, M.D., the first 1976 OSMA Physician's Recognition Award. Dr. Fulton is an OSMA Past President and a Columbus internist.

(**Editor's Note:** *The Journal* will print, on a monthly basis, a listing of Category I continuing medical education courses offered in Ohio. Sponsors of these courses are invited to submit information regarding the programs— please use the form appearing on page 657 of this issue. In order to give physicians sufficient notice of a course, information about an activity should be submitted at least **90 days** prior to the date of the activity. Only Category I courses will be listed.)

Periodic Programs

ANESTHESIOLOGY CONFERENCE: Monday, each week; Toledo Hospital, Toledo; sponsor: Medical College of Ohio at Toledo; 1 credit hour; contact: Paul J. Ditmyer, M.D., 2142 N. Cove Boulevard, Toledo 43606, phone: 419/473-3241, ext. 389.

ENDOCRINE CONFERENCE: Thursday, each week, 10:30 AM-1 PM; Mercy Hospital, Toledo; sponsor: Medical College of Ohio at Toledo; 2 credit hours; contact: John F. Brunner, M.D., 2200 Jefferson Avenue, Toledo 43624, phone: 419/243-8241, ext. 462.

FAMILY PRACTICE TEACHING CONFERENCE: Tuesday, each week; Mercy Hospital, Toledo; sponsor: Medical College of Ohio at Toledo; 1 credit hour; contact: Atilla M. Yefis, M.D., 2200 Jefferson Avenue, Toledo 43624, phone: 419/243-3681.

GRAND ROUNDS: Wednesday, each week, 8 AM; Memorial Hospital; sponsor: Memorial Hospital of Union County; 1 credit hour; contact: Walter R. Burt, M.D., Chief of Staff, London Avenue, Marysville 43040, phone: 513/644-6115.

MEDICAL & SURGICAL GRAND ROUNDS: Thursday, each week, 12 Noon- 2 PM; Community Medical Center Hospital, Marion; sponsor: Community Medical Center; 1 credit hour; contact: Jose G. Albernaz, M.D., Frederick C. Smith Clinic, 1040 Delaware Avenue, Marion 43302, phone: 614/382-8251.

OB/GYN CLINICAL CONFERENCE: Wednesday, each week; Mercy Hospital Professional Center, Toledo; sponsor: Medical College of Ohio at Toledo; 1 credit hour; contact: Homer F. Schroeder, M.D., Mercy Hospital, Toledo 43624, phone: 419/243-8241, ext. 465.

OB/GYN CONFERENCE: First four Thursdays each month through June; Health Education Building, Room 103, West Campus, Medical College of Ohio; sponsor: Dept. of OB/GYN, Medical College of Ohio at Toledo; 3 credit hours; contact: Jack Walters, M.D., P.O. Box 6190, Toledo 43614, phone: 419/381-3460.

OHIO MEDICAL EDUCATION NETWORK (OMEN): September 27, 1976- April 29, 1977; sponsor: Ohio State University College of Medicine, Center for Continuing Medical Education; 1 credit hour; contact: Arthur A. Bartlay, Network Coordinator, OMEN, A352 Starling Loving Hall, Ohio State University, 320 West Tenth Avenue, Columbus 43210, phone: 614/422-4985.

OPHTHALMOLOGY GRAND ROUNDS: Each Saturday; St. Vincent Hospital and Medical Center, Toledo; sponsor: Medical College of Ohio at Toledo; 1 credit hour; contact: Richard Torchia, M.D., 2213 Cherry St., Toledo 43608, phone: 419/473-3561.

PEDIATRIC GRAND ROUNDS: Tuesday, each week; Scott Auditorium, Cleveland Metropolitan General Hospital; sponsor: Department of Medicine, Cleveland Metropolitan General Hospital; 1 credit hour; contact: Donald Medeoris, M.D., Department of Pediatrics, Cleveland Metropolitan General Hospital, Cleveland 44106, phone: 216/791-7300.

PERINATAL CONFERENCE: 4th Wednesday, each month; Toledo Hospital; sponsor: Medical College of Ohio at Toledo; 1 credit hour; contact: Gerald Katzman, M.D., 2142 N. Cove Blvd., Toledo 43606, phone: 419/473-3241, ext. 300.

SURGICAL GRAND ROUNDS: 1st, 2nd, 4th, 5th Thursday each month; Mercy Hospital, Toledo; sponsor: Medical College of Ohio at Toledo; 1 credit hour; contact: Roland A. Gandy, Jr., M.D., 2200 Jefferson Ave., Toledo, phone: 419/243-8241, ext. 464.

SURGICAL SEMINAR: Each Saturday; Room G-1, East Campus, Medical College of Ohio; sponsor: Medical College of Ohio; 2 credit hours; fee: \$10 per session, except MCO faculty, residents, and students; contact: Howard S. Madigan, M.D., P.O. Box 6190, Toledo 43614, phone: 419/381-4237.

TUMOR BOARD: Wednesday, each week; Mercy Hosp., Toledo; sponsor: Medical College of Ohio at Toledo; 1 credit hour; contact: Roland A. Gandy, Jr., M.D., 2200 Jefferson Avenue, Toledo 43624, phone: 419/243-8241, ext. 464.

Single Course Offerings

November 1976

GASTROENTEROLOGY UPDATE 1976: November 17-18; Bunts Auditorium, Cleveland Clinic Educational Foundation, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 13½ credit hours; fee: \$100 (\$50 resident); contact: Rosalynn Presby, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

ELECTROMYLOGRAPHY: November 30; Riverside Methodist Hosp., Columbus; sponsor: Riverside Methodist Hosp.; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

LIVER DISEASES: November 30; University of Cincinnati Medical Center; sponsor: Department of Pathology, University of Cincinnati; cosponsor: CONMED; 5½ credit hours; fee: \$50; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

December 1976

PRACTICE MANAGEMENT SEMINAR: December 1; Medical-Surgical Classrooms, Akron City Hospital; sponsor: Akron City Hospital; 5¼ credit hours; fee: \$20 (\$10 resident); contact: Family Practice Center, Akron City Hospital, 525 East Market Street, Akron 44309, phone: 216/375-3584.

(continued on page 656)

Continuing Education *(continued)*

RESPIRATORY DISEASE IN PEDIATRICS: December 2; sponsors: Northern Ohio Pediatric Society, Department of Pediatrics of Lakeside Hospital, and Case Western Reserve University School of Medicine; 2 credit hours; contact: S. S. Strassman, M.D., Department of Pediatrics, Lakeside Hospital, 2045 Adelbert Road, Cleveland 44106, phone: 216/791-7300.

OPHTHALMOLOGY (Perspectives in): December 2-3; Bunts Auditorium of Education Building; sponsor: Center for Continuing Medical Education, The Cleveland Clinic Educational Foundation; 14 credit hours; fee: \$150; contact: Director of Continuing Medical Education, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

CARDIOVASCULAR DISEASE FOR ORAL SURGEONS: December 3-4; University of Cincinnati Medical Center; sponsor: CONMED; 16 credit hours; fee: \$100; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

TRAUMA (24th Annual Symposium): December 3-4; Harper Hospital, Detroit, Michigan; sponsors: Michigan Committee on Trauma of the American College of Surgeons and Wayne State University Department of Surgery; 11 credit hours; fee: \$150; contact: Joseph L. Posch, M.D., Chairman, 24th Annual Symposium on Trauma, 14th Floor, Kales Building, 76 W. Adams, Detroit, Michigan 48226, phone: 313/962-0727.

ESTROGEN THERAPY IN THE MENOPAUSAL SYNDROME: December 4; Mercy Medical Center, Lecture Hall, Springfield; sponsor: Mercy Medical Center; 1 credit hour; contact: Ernest Henson, M.D., 1343 Fountain Boulevard, Springfield 45501, phone: 513/399-7121.

INFECTIOUS DISEASE CONFERENCE: December 7, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: December 14, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

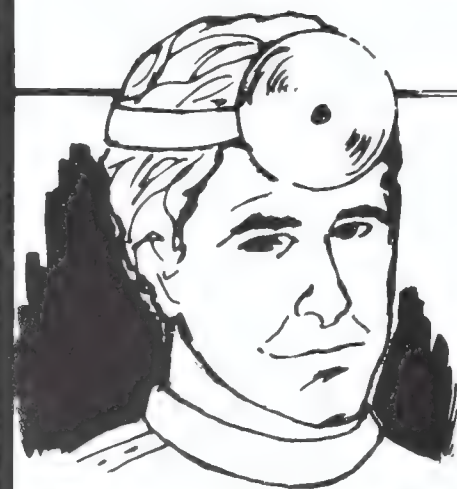
LABORATORY VALUE — FACT NOT FANTASY: December 14, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

NEURO-PATHOLOGICAL CONFERENCE: December 14; Veterans Administration Hospital, Chillicothe; sponsor: Veterans Administration Hospital; 1 credit hour; contact: Assistant Chief of Staff, Veterans Administration Hospital, Chillicothe 45601, phone: 614/773-1141.

MEDICINE AND ORAL FACIAL PATHOLOGY: December 15; Medical-Surgical Classrooms, Akron City Hospital, Akron; sponsor: Akron City Hospital; 3 credit hours; contact: Ms. Linda Kerlee, Akron City Hospital, 525 East Market Street, Akron 44309, phone: 216/375-3203.

ECHOCARDIOGRAPHY: December 18; Lecture Hall, Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour; contact: Ernest Henson, M.D., Mercy Medical Center, 1343 Fountain Boulevard, Springfield 45501, phone: 513/399-7121.

(continued on page 662)



“You’re The Doctor!”

Only you can take the proper safeguards that will provide an income in the event you’re disabled. The OSMA co-sponsored **Disability Income Protection Plan** will assure you of as much as \$500 in weekly benefits when disabled.

More protection for you, doctor:

The **O.S.M.A. Group Term Life Plan** offers coverage up to \$100,000. 44% of last year’s premium was returned as a dividend. (Dividends are not guaranteed.)

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4015 Executive Park Drive Cincinnati, Ohio 45241. Phone (513) 563-4220

1900 Euclid Avenue Cleveland, Ohio 44115 Phone (216) 771-4747
3450 West Central Avenue Toledo, Ohio 43606 Phone (419) 535-0616

CONTINUING MEDICAL EDUCATION COURSE ANNOUNCEMENT

All organizations offering Category 1 continuing medical education activities for physicians are invited to submit information of these activities for publication in *The Ohio State Medical Journal*. Information must be submitted a minimum of 90 days prior to the date of the event to be listed.

Title of Activity _____

Date(s) of Activity _____

Location: Place _____

Address _____

City _____ Zip _____

Designed for (list medical area): _____

Sponsor: _____ Cosponsor: _____

Is Activity Category 1: Yes _____ No _____

Hours of Credit: _____

Registration Fee: No _____ Yes _____ Amount \$ _____ (Indicate if different for students or physicians-in-training.)

For further information contact: Name _____

Address _____

City _____ Zip _____

Telephone: () _____

Person Completing Form: _____

Title: _____ Telephone: _____

**Return to: Ohio State Medical Association
Department of Continuing Medical Education
600 South High Street
Columbus, Ohio 43215
(614) 228-6971**

(This form may be duplicated.)

COLLEAGUES IN THE NEWS

Ohioan Installed as President Am. Academy of Family Physicians

B. LESLIE HUFFMAN, JR. M.D., Maumee, was inaugurated President of the American Academy of Family Physicians (AAFP) at the Academy's annual meeting held during September in Boston. Previously, he served as Speaker of the Congress of Delegates of the AAFP. He is a Fellow of that organization.

Dr. Huffman, a Charter Diplomate of the American Board of Family Practice who has been practicing Family Medicine in Toledo and Maumee since 1956, is a Clinical Associate Professor and the Acting Chairman of the Department of Family Medicine at the Medical College of Ohio at Toledo.

Dr. Huffman is an OSMA Alternate Delegate to the AMA's Congress of Delegates as well as a Delegate to the AMA's Council of Medical Specialty Societies. In addition, he served on the AMA Section Council on Family and General Practice and is Chairman of Scientific Exhibits Program.

An OSMA Delegate since 1972, Dr. Huffman is also on its PSRO Council, Specialty Panel on Family Practice. He was President of the Ohio Academy of Family Physicians in 1967-1968 and has also served as President of The Toledo-Lucas Academy of Family Physicians. He holds trusteeships in the Family Health Foundation of America and the Family Physicians Political Action Committee and is very active in the Academy of Medicine, Toledo-Lucas County.

Dr. Huffman is on the active staffs of St. Luke's, Maumee Valley, and Toledo Hospitals. At the latter, he has held numerous positions including Chief of the General Practice Section and Associate Director of the Family Practice Residency Program.



Left to right: B. Leslie Huffman, Jr., M.D., President, and Carl Hall, M.D., Immediate Past President, the American Academy of Family Physicians. (Photo courtesy the Academy.)

GEORGE BALLOU, M.D., has been installed as president of the medical staff of Christ Hospital, Cincinnati. Dr. Ballou, a member of the Department of General Surgery, has been on the hospital staff since 1951. He is also team physician for the Cincinnati Reds, the Bengals, and the Stingers.

Also installed were **ROBERT HEIDT, M.D.**, vice president; and **JAMES GARVEY, M.D.**, secretary-treasurer. Dr. Heidt is Director of the Department of Orthopedics at Christ Hospital. In addition, he serves as Chairman of the OSMA Emergency Medical Services Committee; President of Tri-Regional Emergency Medical System, Inc.; and Chairman of the Medical Advisory Committee for the March of Dimes.

Dr. Garvey, a member of the Christ Hospital Department of Internal Medicine, Section of Cardiology, serves as Associate Clinical Professor of Medicine at the University of Cincinnati College of Medicine.

HARRY BERLEY, M.D., Yellow Springs, celebrated his 25th year working with nurse Clara Geis. Twenty years ago, **CARL HYDE, M.D.**, joined the two in the general practice office. Today seven other persons work on the Berley and Hyde staff.

THOMAS J. BEYNON, M.D., has become the full-time director of Weirton (West Virginia) General Hospital. Dr. Beynon had previously held this post on a part-time basis while continuing his private practice.

JORDAN DENTSCHKEFF, M.D., has been elected President of The Youngstown Society of Obstetricians and Gynecologists which was organized last summer. Dr. Dentscheff stated, "This society is new but very vital in representing northeastern Ohio and western Pennsylvania obstetricians and gynecologists. Our quarterly meetings will be of very high scholastic-academic standards and the ultimate goal of the society is to give the best possible obstetrical and gynecological care in this vicinity."

Other officers of the organization are **JOHN GUJU, M.D.**, president-elect; **MILTON LENHART, M.D.**, secretary-treasurer; **VINCENT LEPORE, M.D.**, assistant secretary-treasurer; and **S. W. CHIASSON, M.D.**, and **PAXTON JONES, M.D.**, members-at-large of the executive committee.

EDWARD PURNELL, M.D., Professor and Chairman of the Department of Ophthalmology at Case Western Reserve University, was the featured speaker at the first meeting of the organization.

HARRY L. DUNCAN, M.D., received a letter of commendation from the Ohio House of Representatives on the occasion of his retirement after 32 years of practice in the Matamoras area. The letter, signed by State Representative Sam Speck and Speaker of the Ohio House Vernal G. Riffe, Jr., cited Dr. Duncan's "dedication to performing (his) duties and fulfilling (his) responsibilities with the utmost efficiency and competence."

JERRY THOMAS GUY, M.D., has been appointed Coordinator of Education- Medicine at Grant Hospital in Columbus. Dr. Guy had served as Chief Resident in Medicine at The Ohio State University.

RALPH S. HOSLER, M.D., Ashville, retired from practice in September after serving the community for 59 years. The 87-year-old Dr. Hosler was graduated from Starling Ohio Medical School, now a part of The Ohio State University's School of Medicine, in 1917.

C. J. IDE, M.D., Bucyrus, has been appointed to a second term as a member of the Crawford County Mental Health Board by the Crawford County commissioners. Dr. Ide's re-appointment is for four years.

ROBERT J. LERER, M.D., Fairfield, has been appointed Butler County Health Commissioner. Dr. Lerer, a pediatrician, was formerly medical director for the county department.

TEARLE L. MEYER, M.D., Columbus, has been elected President of the Ohio State Radiological Society. Dr. Meyer is a member of Grant Hospital's Radiology Department and is president-elect of the hospital's medical staff.

M. S. N. MURTHY, M.D., Columbus, has been elected a Fellow of the Royal College of Pathologists of Great Britain.

EARNEST PERRY, M.D., a Youngstown surgeon, was recently honored for "his dedication to community improvement" at a testimonial dinner. Dr. Perry, a Diplomate of the American Board of Surgery and a member of the medical staff of the Youngstown Hospital Association, was cited for being a "Man of compassion, who gives his help without seeking recognition." His civic activities include being a director of the Youngstown Area Development Corporation and a team physician.

H. WILLIAM PORTERFIELD, M.D., Columbus, has been elected Assistant Secretary of the American Society of Plastic and Reconstructive Surgeons. Dr.

Porterfield, who also serves as a member of the Board of Directors of the Educational Foundation of the Society, is an OSMA Delegate to the American Medical Association. In addition, he serves as Chairman of the Ohio Medical Political Action Committee (OMPAC) and is Chairman of the Health Facilities and Services Committee of the Franklin County Health Planning Council.

RUSSELL RIZZO, M.D., Cleveland, has been named president of the Case Western Reserve University Medical Alumni Association. Dr. Rizzo is on the staffs of both Lakewood and St. Johns Hospitals and is a past-president of the Ohio Orthopedic Society.

MORRIS S. ROSENBLUM, M.D., Youngstown, was honored by The Ohio State University at the 1976 summer commencement exercises in Columbus. O.S.U.'s Distinguished Service Award was conferred upon Dr. Rosenblum for his exceptional efforts on behalf of the university's Medical Alumni Association and the Mahoning County Chapter of the school's Alumni Association. Dr. Rosenblum, since receiving his M.D. degree from O.S.U. in 1932, has served as president of both the county chapter and the medical alumni associations of the university and is currently a member of the O.S.U. Alumni Advisory Board.

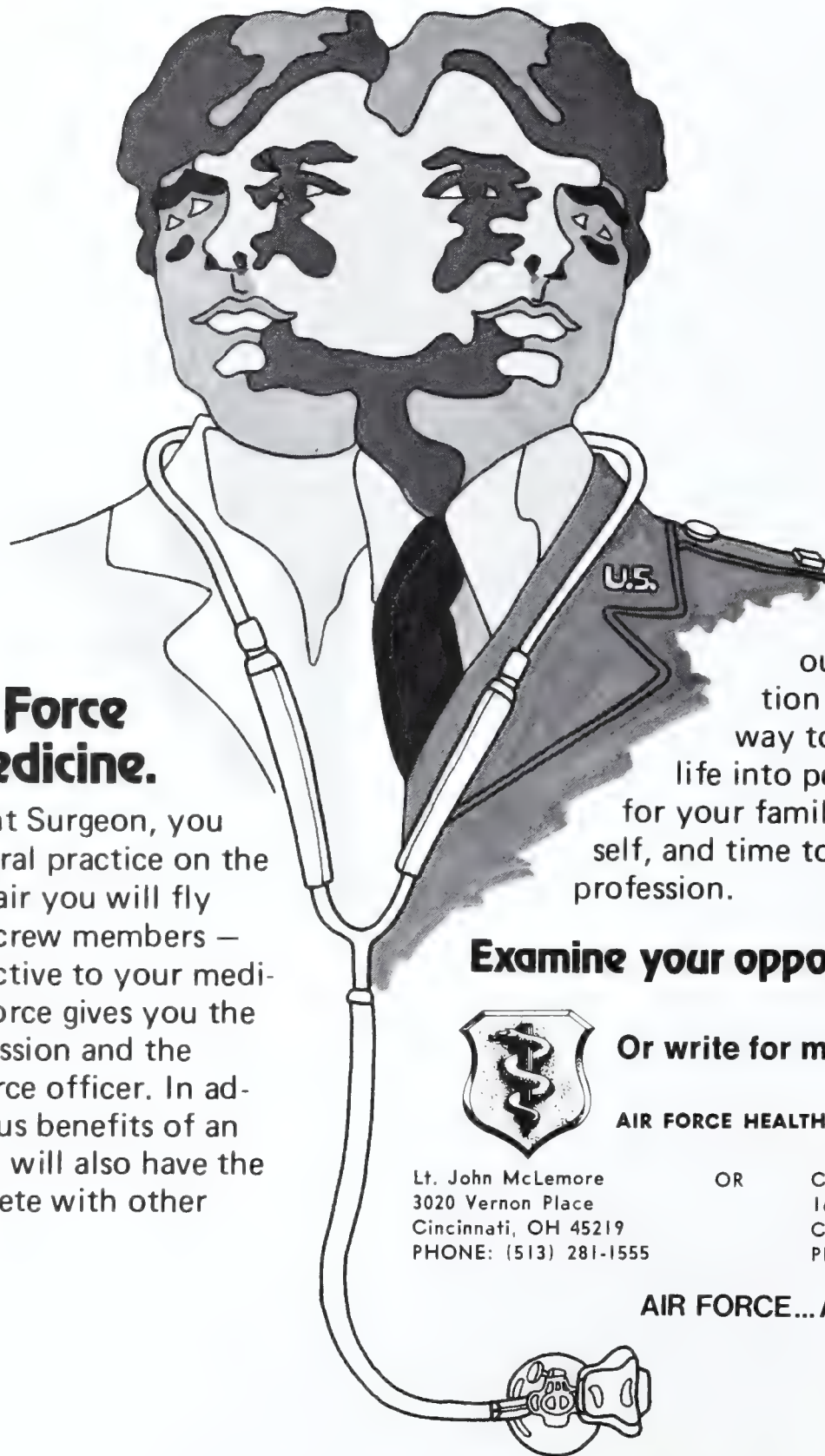
CLINTON W. STALLARD, M.D., Cleveland, has been appointed director of medical services for The Standard Oil Company of Ohio. He will be responsible for all corporate medical activities, including the industrial hygiene and toxicology programs. Dr. Stallard, who previously served as medical director of the Newport News, Virginia, Shipbuilding and Dry Dock Company, is board certified in preventive medicine and a Fellow of the American College of Preventive Medicine.

ROBERT M. ZOLLINGER, M.D., Columbus, Professor Emeritus of Surgery at University Hospitals, was awarded an Honorary Doctor in Medicine degree from the Medical School of the National University of Athens, Greece. Dr. Zollinger has been active in the visiting professorship programs between University Hospitals and the University of Athens.



During October, **HOMER A. ANDERSON, M.D.**, a Columbus pediatrician, brought eight, first-year, medical students with whom he works to the OSMA Headquarters Office. OSMA staff informed The Ohio State University College of Medicine students of the benefits of Association membership. Dr. Anderson gives all his students the opportunity of such a visit.

To the physician whose practice needs a new perspective.



Look into Air Force Aerospace Medicine.

As an Air Force Flight Surgeon, you will have a truly general practice on the ground, while in the air you will fly with and observe air crew members — adding a new perspective to your medical career. The Air Force gives you the respect of your profession and the prestige of an Air Force officer. In addition to the numerous benefits of an Air Force career, you will also have the opportunity to compete with other

physicians for an outstanding education program. It's the way to pull your entire life into perspective — time for your family, time for yourself, and time to advance in your profession.

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OR

Capt. Roland Carroll
16101 Snow Rd., Suite 300
Cleveland, OH 44142
PHONE: (216) 522-4325

AIR FORCE... A Great Way of Life

OSMA Launches 1976 AMA-ERF Campaign

Physicians and Auxilians, you should be proud of your contributions to the American Medical Association Education and Research Foundation (AMA-ERF) during 1975. Ohio's six medical schools received a total of \$62,742.50 this year as a result of your generosity during the 1975 campaign.

The 1975 contribution total represents an increase of 50.5 percent over the \$41,675.12 donated during the 1974 campaign.

Can the 1976 campaign be as successful? Can contributions again show a major increase? Why not! Your dollars play a vital role in the future of the medical profession.

Philip Hardymon, M.D., Columbus, Chairman of the Ohio AMA-ERF Committee, which includes the 12 District Councilors of OSMA, pointed out that large numbers of outstanding medical students, interns, and residents have only one major barrier to hurdle before taking their place on the front line of health care delivery. That barrier is the *lack of adequate funding* for the remainder of their education.

Dr. Hardymon cited the following statistics:

(1). A total of 165 loans were made to medical students, interns, and residents in Ohio during 1975. These loans amounted to \$252,600— an increase of nearly \$40,000 over 1974.

(2). During the past ten years, a total of 976 loans have been made in Ohio. The loans amount to \$2,725,550.

(3). Total contributions to AMA-ERF throughout the nation during 1975 (distributed to medical schools in 1976) were \$1,274,999.83.

The distribution to individual medical schools in Ohio during 1976 is as follows:

The University of Cincinnati College of Medicine \$18,492.37; Case Western Reserve University School of Medicine \$13,038.27; Medical College of Ohio at Toledo \$5,878.65; The Ohio State University College of Medicine \$16,479.74; Northeastern Ohio Universities College of Medicine \$3,581.84; and Wright State University School of Medicine \$5,271.63.

All this has been done by a private sector of the economy without government subsidy. This enviable record can be maintained with the help of Ohio physicians. Here are answers to some questions you may have concerning the Student Loan Guarantee Fund.

Did you know that through the Student Loan Guar-

antee Fund, the struggling medical student may receive direct financial aid?

Did you know that with increasing inflation, it now costs more than \$5,000 per year to attend medical school?

Did you know that your contribution to the Student Loan Guarantee Fund will be held as a guarantee for repayment of loans? For each \$1 you give, another \$12.50 will be put to work in loans made by a commercial bank; and as these loans are repaid, the money is reactivated to help other students.

Did you know that the accepted applicant becomes eligible for medical education loans of up to \$1,500 a year? Additional applications may be approved each year so that a maximum of \$10,000 can be borrowed over a seven-year period.

Did you know that the borrower pays only the established interest rate during his training and has ten years after completion of training to repay the principal?

How do you contribute? Shortly after you receive this issue of *The Journal*, you will receive a letter from Dr. Hardymon and a special AMA-ERF return envelope. The inside of the envelope includes space for your choice of medical school to receive your contribution, choice of category for your contribution, and the amount of your contribution. The pre-addressed envelope containing your contribution goes directly to AMA-ERF headquarters in Chicago.

In summary, the AMA-ERF student loan program has been designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine. AMA-ERF functions as a cosigning agency to make available through community banks relatively large sums of credit at a low rate of interest.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Hardymon and members of the Ohio AMA-ERF Committee urge Ohio physicians to respond generously in this year's campaign.

You, Doctor, can become an important part of this program by contributing now. Where else can you buy so much for so little? Just think, a tax deductible contribution of \$125 would guarantee a medical student's loan for one year.

If you have questions or need further information concerning the 1976 AMA-ERF campaign, don't hesitate to contact the OSMA office at 600 South High Street, Columbus 43215. Telephone 614/228-6971.

January 1977

INFECTIOUS DISEASE CONFERENCE: January 4, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

NUCLEAR MEDICINE: January 10-14; Nuclear Medicine Institute, Hillcrest Hospital, Cleveland; sponsor: Nuclear Medicine Institute; 40 credit hours; fee: \$500 (\$200 resident); contact: D. Bruce Sodee, M.D., Director, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370.

TRANSPHENOIDAL HYPOPHYSECTOMY FOR CANCER OF BREAST AND PROSTATE — Current Status and Medication for Pituitary Surgery: January 11; 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 2 credit hours; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

FAMILY MEDICINE REVIEW: January 15-16, 29-30; Imperial House North, Columbus; sponsor: Ohio Academy of Family Physicians; 12 credit hours/weekend; fee: \$75 member/weekend, \$125 nonmember/weekend, \$25 resident/weekend; contact: Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

THROMBOEMBOLIC DISEASE: January 18, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 2 credit hours; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

HYPERTENSION: EVALUATION AND THERAPY IN PRIMARY CARE PRACTICE: January 19; Biltmore Towers Hotel, Dayton; sponsor: Greene Memorial Hospital; 6 credit hours; fee: \$25; contact: Arlene Polster, Greene Memorial Hospital, Xenia 44385, phone: 513/429-3200.

ANESTHESIOLOGY (Visiting Professor Program): January 21; Health Education Building, Medical College of Ohio at Toledo; sponsor: Medical College of Ohio; 3 credit hours; contact: John T. Martin, M.D., P.O. Box 6190, Toledo 43614, phone: 419/381-3556.

CME AT RIVERSIDE METHODIST HOSPITAL: January 25, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: January 25, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medi-Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

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The Ohio State Medical Association



Announces Formation of

The Physicians Insurance Company of Ohio

A Physician's Professional Liability Insurance Carrier

On August 1, 1976, the OSMA House of Delegates overwhelmingly approved the formation of an insurance company to be owned by the physicians of Ohio and the OSMA. The Physicians Insurance Company of Ohio (PICO) has been incorporated and is presently offering for sale shares of stock in the Company.

The Ohio Company to Offer PICO Stock

PICO securities are being offered for sale only by The Ohio Company, by means of an Offering Circular. This Offering Circular will be mailed to all members of the OSMA.

OSMA-member physicians who are residents of Ohio are qualified to purchase stock. In addition, Ohio medical partnerships or corporations whose principal office is in Ohio may purchase shares on behalf of their member physicians.

The stock being offered consists of 12,000 shares of Class A Common Stock and 100 shares of Class B Common Stock. The latter have already been sold to the OSMA, and the Class A Stock will be offered to OSMA physicians and/or Ohio medical partnerships or corporations. Both types of stock cost \$1,000 per share.

Any questions regarding purchase of PICO stock should be directed to your nearest **Ohio Company** representative. Questions regarding insurance should be directed to the OSMA, 600 South High Street, Columbus 43215. Telephone: 614/228-6971.

Turn page for information on the type of professional liability insurance to be offered by The Physicians Insurance Company of Ohio.

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COMPLETE and MAIL this form today.

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This purchase requirement is necessary so that physicians with higher risk classifications and accompanying higher premiums supply the Company with a proportionate amount of surplus as regards policyholders. PICO has determined that good insurance practice requires the Company to maintain at all times a ratio of net premiums to surplus as regards policyholders of not more than two to one (2:1).

PICO will initially offer an occurrence policy with \$100,000/\$300,000 limits. There will be no excess coverage written initially. The Company will, however, offer its insureds an endorsement to its policies to provide "tail" coverage to cover claims discovered and reported after the termination of a "claims-made" policy. This endorsement would apply to "claims-made" policies issued by the JUA, Lloyds, or any other "claims-made" policy.

The consent of the insured physician will be required to settle a claim.

It should be noted that purchase of stock does not guarantee insurability. Other customary underwriting criteria will have to be satisfied as well.

PICO intends to file the following initial premium rates with the Ohio Department of Insurance in connection with its application for a Certificate of Authority. There can be no assurance that these premium rates will not be challenged, but the Company is not presently aware of any objection to them.

Risk Classification	Initial Premium Rates
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III	\$3,289
IV	\$5,482
V	\$6,577
V-A	\$8,770



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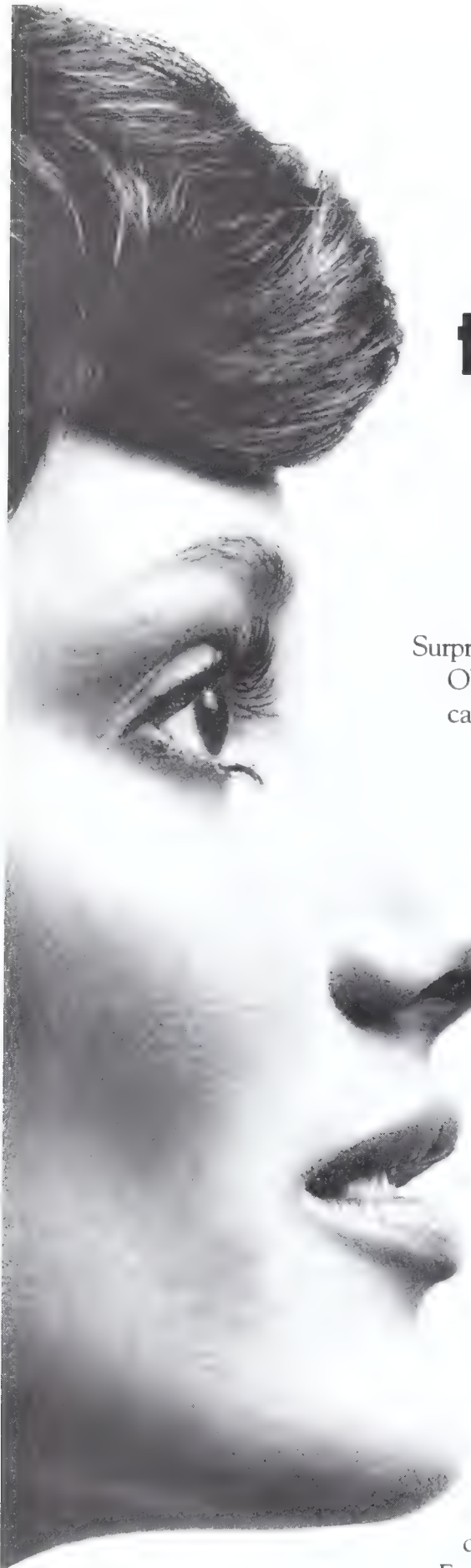
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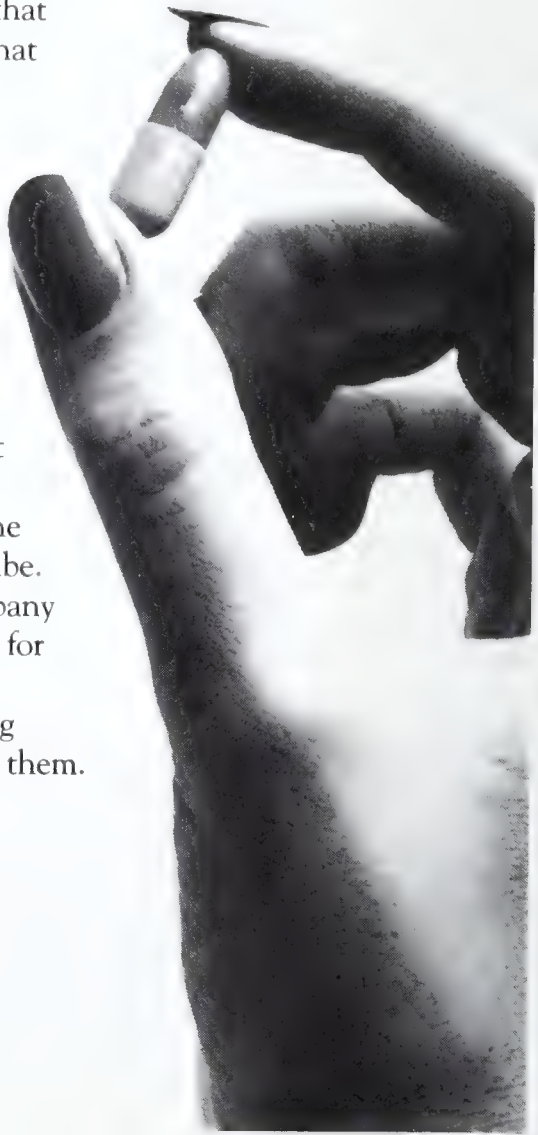
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Adenocarcinoma of the Corpus Uteri

Mostafa A. Selim, M.D.
Michael R. Neuman, M.D., Ph.D.
Ahmad Razi, M.D.
Wladyslaw Topolnicki, M.D.

One hundred and seventeen patients with endometrial carcinoma are reviewed. Sixty-two percent had stage I disease; 67 percent were between the ages of 50 and 69 years; 19 percent were premenopausal; and abnormal or postmenopausal bleeding prompted medical consultation in 92 percent. Cytologic smears were positive in only 30 percent of the patients. Primary malignancies of other organs were noted in 8 percent. Treatment was surgical with or without radiation, or irradiation alone. The overall, corrected, five-year survival rate was 70 percent. Isolated vaginal recurrences were rare, but were higher (23 percent) in surgical cases only, in comparison to surgical treatment plus irradiation (4 percent). Survival was affected by age at diagnosis, state of the disease, depth of myometrial invasion, and cellular differentiation of the tumor. To improve the survival rate, high-risk groups of patients should be considered for early detection, and an improved treatment protocol is suggested using the prognostic factors.

THE INCIDENCE OF adenocarcinoma of endometrium has increased steadily in recent decades,^{1,2} and the ratio of adenocarcinoma of endometrium to invasive carcinoma of the cervix uteri is almost one to one.^{3,4} If these trends of increase in endometrial carcinoma and decrease in invasive cervix cancer continue, endometrial carcinoma will become a greater problem than carcinoma of the cervix.¹

Despite the apparent increase in the importance of this type of cancer, there is an absence of controlled clinical studies to provide firm guidance in individualization of therapy.⁴ The main objective of this study is to review our previous experience in an effort to reduce our

bias and to be more objective in our management of endometrial carcinoma.

Materials and Methods

One hundred and seventeen patients with histologic diagnosis of adenocarcinoma of the endometrium were registered at the Cleveland Metropolitan General Hospital Tumor Registry from 1955 through 1969. A review of the hospital and tumor registry records provided the data for this study.

Diagnosis was established by tissue sections in all cases. Specimens were obtained by dilation and curettage in the hospital.

Staging was retrospective, but adequate data were available to classify all patients properly. Staging was recorded by using the criteria established by the International Federation of Obstetricians and Gynecologists (FIGO) at the Sixth World Congress.⁵

Treatment Methods.—The usual method of treatment for stage I tumors was preoperative radiation followed in six weeks by total hysterectomy and bilateral salpingo-oophorectomy including an excision of a 2.0-cm vaginal cuff. Preoperative radiation provided by the Heyman radium-packing technique, for a total dose of 4,000 to 6,000 mg-hr, was given. Vaginal radium sources in colpostats, plaques, or ovoids seldom were administered in the radiotherapy and/or preoperative groups, to deliver 6,000 rads to the vaginal mucosa.

Postoperative radiation therapy was administered to the pelvis if (1) there was over one-third myometrial penetration by tumor; (2) tumor had spread outside the

uterus to pelvic lymph nodes, adjacent organs; or (3) grade 3 tumor was found in the specimen. The dosage of external irradiation employed varied between 3,000 and 4,000 rads, by opposing fields over a period of four to five weeks.

When stage I tumors were treated by primary operative therapy, the usual procedure was total abdominal hysterectomy, bilateral salpingo-oophorectomy and wide vaginal cuff. The cervix was not sutured.

The treatment of tumors involving both the cervix and fundus (stage II) consisted of preoperative Heyman's capsules and vaginal radium sources followed by hysterectomy. In patients found to have deep myometrial penetration, additional postoperative radiation was administered to provide a dose of 5,000 rads to the entire pelvis. Patients who were not suitable for surgery were treated by intracavitary and external irradiation to provide doses similar to that administered in primary carcinoma of the cervix.⁶

Stage III and IV lesions were treated by radium and external radiation therapy. The goal was to provide doses of radiation similar to that given in primary carcinoma of the cervix.⁶

All patients were operated on by the residents in training.

In data analysis, all patients lost to follow-up were considered to have died of cancer.

Results.—Of the 117 patients studied, three were lost to follow-up prior to five years following treatment. Thirteen patients did not receive any treatment (three stage I, five each from stages III and IV) because the patient refused or the medical condition did not allow treatment.

Symptoms.—Postmenopausal bleeding was the most common symptom which occurred in 73 percent of the patients studied; 19 percent presented with menometrorrhagia; 10 percent presented with vaginal discharge; and 2 percent presented with pain.

Medical Status.—Forty-six patients (40 percent) had hypertension or cardiovascular disease. Frank diabetes was

found in 27 patients (23 percent). Secondary primary cancer was found in ten patients (8 percent). The incidence of concurrent diseases in other series varies. For diabetes, it ranges from 5.3 to 41 percent;^{7,8} hypertension from 33 to 66 percent;^{7,8} obesity from 17 to 40 percent;^{7,9} and for secondary primary from 7.7 to 20 percent.^{8,10}

Gravidity.—Of the series, 37 patients (31 percent) were nulliparous, which is higher than the figure of 17.9 percent for average population;^{11,12} 36 percent were gravida 1 or 2. The remaining patients were over gravida 3.

Inaccuracy of the Papanicolaou Smear.—In this series, 98 patients had records of cytologic smears which had been taken. In 69 (70 percent) of the reported smears, a false negative result was obtained, and this result is comparable to other series.^{10,13}

Factors Influencing Survival.—**Age:** Nineteen patients (16 percent) had cancer before the age of 50 years, and 79 patients (67 percent) had developed cancer between the ages of 50 and 69 years. The mean age for all cases was 59 years. The mean age for stage I cases=57 years, stage II=64 years, stage III=61 years, and stage IV=66 years.

Excluding all cases not receiving any form of therapy (13 patients), the following results deal with patients who completed their therapy (104 patients).

Table 1 shows the prognosis is much worse in older patients. These findings support the findings of others in literature.^{10,14}

Stage of Disease and Survival.—Table 2 shows the five-year survival in the series when divided into stages. The

TABLE 1. Age and Survival of Patients Treated for Carcinoma of Endometrium

Ages (Years)	Patients Treated	Five-Year Survival* No.	%
40 - 49	16	14	87
50 - 59	36	29	80
60 - 69	36	24	66
70 - 79	15	6	40
80 - 89	1	0	0
Total	104	73	70

* Corrected for other causes of death.

TABLE 2. Stages and Survival Rates of Patients

Stage	Patients Treated	Five-Year Survival* No.	%
IA	69	52	86
IB	9	7	77
II	18	12	67
III	4	1	25
IV	13	1	8
Total	104	72	70

* Corrected for other causes of death.

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Dr. Razi, Falls Church, Va., formerly Resident in Obstetrics and Gynecology, Cleveland Metropolitan General Hospital; currently Clinical Instructor, Department of Obstetrics and Gynecology, George Washington University School of Medicine, Washington, D.C.

Dr. Topolnicki, Cleveland, Chief of Radiotherapy Service, Cleveland Metropolitan General Hospital; and Assistant Professor of Radiology, Case Western Reserve University School of Medicine.

Submitted February 6, 1976.

TABLE 3. Relation Between Survival and Invasion of Myometrium

Degree of Penetration	Patients Treated	Stages I - IV	
		Five-Year Survival* No.	%
No tumor seen	37	35	95
Confined to endometrium	16	16	100
Superficial	5	3	60
Deep under two-thirds	6	0	0
Deep over two-thirds	3	0	0
No hysterectomy specimen	37	19	51
Total	104	73	70

* Corrected for other causes of death.

largest number of patients were in the stage IA category. The difference between an 86 percent survival rate in stage IA, as compared to 8 percent in stage IV, is self-evident.

Degree of Myometrial Penetration.—The relation between survival and myometrial invasion is shown in Table 3. When the tumor penetrated deep in the myometrium, there was no survival. Hysterectomy specimens were not available for 37 patients as they were treated by irradiation. There was no significant difference in survival between patients without residual and patients with residual confined to the endometrium. But as soon as the tumor invaded the myometrium, the survival decreased with the increase in penetration. The relationship between prognosis and myometrial invasion has been confirmed by others.^{8,10,11,15,16}

Grade.—Table 4 shows the relationship between survival and the grade of the tumor in stages IA and IB separately because they comprise 62 percent of all cases registered and 66 percent of all cases treated. In addition, the international staging divides stage I cases into grades 1, 2, and 3. It appears that grade 1 has the best survival rate; and survival decreases by the decrease of the degree of differentiation. Table 5 demonstrates this relation in the whole series, and the difference between grade 1 and grade 3 is more marked. This phenomenon has been demonstrated by others.^{10,11,15,17} The incidence of adenocarcinoma in these series is 12 percent.

Treatment and Survival.—Table 6 shows the survival rate in stage I in relation to type of therapy and the grade.

TABLE 4. Relationship Between Survival and Grade of Tumor in Stages IA and IB

Grade	Patients Treated	Stages IA and IB*	
		No.	%
1	46	44	96
2	17	11	65
3	6	4	66
Total	69	59	87

* Corrected for other causes of death.

TABLE 5. Relationship Between Survival and Grade of Tumor in Whole Series*

Grade	Patients Treated	Stages I - IV	
		No.	%
1	55	51	93
2	29	16	55
3	20	6	30
Total	104	73	70

* Survival corrected for other causes of death.

It appears that the combined therapy showed better five-year survival than surgery and radiotherapy alone in grades 2 and 3, and surgery alone showed the poorest survival rate in grade 1.

Stage II: There were only 18 patients classified as stage II. One patient was treated by total abdominal hysterectomy with no five-year survival. Ten patients were treated by combination of radiation and hysterectomy with a corrected survival rate of 80 percent. Seven patients were treated by a combination of intracavitary and external irradiation with a corrected survival rate of 59 percent (Table 7).

Stage III: Nine patients were diagnosed as stage III. Five of these received no treatment. One patient was treated by irradiation and surgery but did not survive five years. Three patients were treated by irradiation and one survived over five years (Table 7).

Stage IV: Eighteen patients were diagnosed as stage IV. Five of these were not treated. Two patients were treated by a combination of irradiation and surgery, and

TABLE 6. Survival Rate of Stages IA and IB Tumors in Relation to Grade and Type of Therapy*

Grade	Grand Total		Surgery	Five-Year Survival		Combined	Radiation	
	No.†	%	No.	%	No.	%	No.	%
1	44/46	96	8/10	80	25/26	96	10/10	100
2	11/17	65	1/2	50	9/12	75	1/3	33⅓
3	4/6	66	0/1	0	2/2	100	2/3	66⅔
Total	59/69	87	9/13	75	36/40	90	13/16	80

*Survival corrected for other causes of death.

†Five-year survivors/total cases

none survived. Seven patients were treated by irradiation, and only one survived over five years (Table 7).

Recurrences.—Upper-vaginal vault recurrences occurred in two patients of the combined therapy group (4 percent) and in three patients of the surgical group (23 percent). These results correlate well with other series.^{8,18,19}

Discussion

It has been said for years that earlier diagnosis is the key for improved results in endometrial carcinoma.^{20,21} In the face of known limitations of the Papanicolaou's smear in these series and other experiences in endometrial lesions,^{4,10,13} our tendency is to employ endometrial biopsy with increasing frequency in diagnosis of abnormal uterine bleeding. In recent years, we have employed the endometrial jet washer²² more frequently for preliminary diagnosis in abnormal uterine bleeding, as well as in routine check-up in high-risk patients (diabetic, hypertensive, obese patients and/or patients with another primary site of adenocarcinoma). If we are to improve in early diagnosis, we must pay more attention to the latter group of patients, following the lead of those who carry out routine endometrial sampling as part of a regular examination.^{21,23,24} Furthermore, we must define the premalignant lesions more accurately.²⁴

Several significant factors can influence the prognosis in patients with adenocarcinoma of the endometrium.

The majority of the previous studies stressed the significance of the histologic grade of tumor, uterine size, and the presence or absence of tumor in the cervix.^{3,4,10,11,15,17} The age factor has been ignored except in recent reports.^{5,10,14,15-27} These reports, as well as results of our studies, indicate that older patients have poorer prognoses than younger patients. The age effect on prognosis is difficult to explain. Several reports have demonstrated that women with histologic grade 1 carcinoma are younger than those with grade 3 carcinoma.^{17,21} These findings are explained in part by an alteration of the histologic behavior of the endometrial cancers among older women.² The prognostic effect of age on survival cannot be explained in this study by stage as there was no significant difference between the mean age of the different clinical stages.

Cheon²⁵ and Kurohara et al²⁶ have shown, by including the age factor with other clinicopathologic factors, that they can devise a better score for predicting the prognosis of adenocarcinoma of the endometrium.

Another factor, which has been ignored by international staging of adenocarcinoma of the endometrium, is the degree of myometrial invasion. The relationship between survival and myometrial penetration has been demonstrated by several studies^{8,10-12,15} and is confirmed in the present study. Other studies also have shown that the degree of myometrial invasion correlates well with the incidence of lymph-node metastasis.^{27,28}

These results suggest that age and the myometrial invasion factors should be taken into consideration with

TABLE 7. Survival According to Stage, Grade, and Type of Treatment*

Stage and Grade	Surgery		Combined		Irradiation	
	No.†	%	No.†	%	No.†	%
1A:						
G1	5/7	83	26/27	97	10/10	100
G2	1/2	50	7/9	80	0/2	0
G3	0/1	0	1/1	100	1/1	100
Total	6/10*	60	34/37*	92	11/13*	80
1B:						
G1	2/2	100	0	0	0	0
G2	0	0	2/3	66⅔	1/1	100
G3	0	0	1/1	100	1/2	50
Total	2/2*	100	3/4*	75	2/3*	66⅔
II:						
G1	0	0	3/3	100	3/3	100
G2	0	0	3/5	60	1/3	33⅓
G3	0/1	0	1/2	50	0/1	0
Total	0/1	0	7/10	80	4/7	59
III:						
G1	0	0	0	0	0	0
G2	0	0	0	0	1/1	100
G3	0	0	0/1	0	0/2	0
Total	0	0	0/1*	0	1/3*	33⅓
IV:						
G1	0	0	0	0	1/3	33⅓
G2	0	0	0	0	0/3	0
G3	0	0	0/2	0	0/5	0
Total	0	0	0/2*	0	1/11*	9

*Survival corrected for other causes of death.

†Five-year survivors/total cases

other factors in devising a prognostically sound classification for adenocarcinoma of the endometrium.

The role of radiation therapy in the management of carcinoma of the endometrium has been debated considerably in the literature. Opinions vary from a complete rejection of this modality in early operable cases,^{7,11,27} to its acceptance as the primary treatment. The majority of authors consider radiation therapy of great value as an adjuvant to surgery in the management of this form of cancer.^{4,10,15,19,30-33}

The majority of these clinics utilize intracavitary radiotherapy (Heyman's technique)³⁴ as the preferred method of preoperative irradiation. This form of therapy affords a satisfactory rate of tumor disappearance and is less time-consuming than external irradiation.³⁵ Some advocate external irradiation as the preferred form of preoperative irradiation,⁹ while others advocate a combination of external and intracavitary irradiation.³⁵ Unfortunately, there is no controlled study to show the advantage of one modality of treatment over the other. The postoperative use of radium instead of preoperative irradiation also has been debated for the last two decades without conclusive evidence. Recently, Graham¹⁹ and Shah and Green⁸ have shown that there is no demonstrable difference between the effectiveness of preoperative as compared with postoperative radiation. Because of such data, some clinics have altered their management of patients with carcinoma of the endometrium considerably and are using postoperative vaginal irradiation instead of preoperative irradiation.³⁶

In our study, the effect of preoperative irradiation is inconclusive because of the relatively small series. In general, combined therapy produced better results than surgery alone in relation to survival and recurrence rates, especially in patients who had undifferentiated tumor. Radiotherapy alone is employed in patients who are surgical risks. The survival rates in the latter patients are low because the majority die of intercurrent diseases. Salvage rate with radiotherapy alone in patients with undifferentiated tumor and advanced stage is poor.

The results of our study correlate well with other series.^{4,8-10,19,25,31-33,35} To improve the results, we feel we must use all the prognostic factors so as to individualize the treatment of each patient according to the extent of the disease. Recently, several authors have suggested new protocols for treatment of adenocarcinoma of endometrium.^{29,30,37,38} The uterus is removed within a week of radium application to derive the benefits of the histologic effect of the radium and, most importantly, to more accurately determine the extent of myometrial invasion, avoiding destruction by radium if we waited four to six weeks. We agree with these authors, and our protocol for treatment of this disease is summarized in Table 8. In stage IA-grade 1, no preoperative irradiation is given as postoperative vaginal irradiation has equal results to preoperative irradiation,^{11,19,36} and probability of lymph-node metastasis is very low. However, if myometrial invasion is more than 30 percent, whole pelvic irradiation is given. In stage IA, grades 2 and 3, pre-

operative irradiation is recommended, hysterectomy within 72 hours, and external irradiation is recommended only as in stage IA, grade 1. Stage IB, irrespective of the grade of tumor, is treated preoperatively by total pelvic irradiation as the probability of node metastasis is higher in this group. Stage II should be treated as carcinoma of the cervix, either by full irradiation followed by total hysterectomy or by radical hysterectomy and lymphadenectomy, due to the high incidence of parametrial involvement and lymph-node metastasis. Stages III and IV are treated by whole-pelvic irradiation and progestin agents systemically to reduce the tumor population. Adriamycin or bleomycin is advisable as an additive chemotherapeutic agent in cases of mixed adeno-squamous carcinoma with distant metastasis. These last two agents have been shown to have good effect on squamous elements.^{16,33} Total hysterectomy is advisable in all cases whenever the parametrial involvement responded to the radiation and chemotherapy. This will reduce the tumor population and prevent persistent disease and, hence, may improve the survival rate and/or palliative effect of therapy.

Conclusions

Reviewing the results of this and previous studies, the following conclusions can be reached:

- (1) Papanicolaou's smear is greatly limited as a screening method for adenocarcinoma of the endometrium. Other methods, such as endometrial biopsy and/or endometrial jet washer, are needed to improve the detection rate.
- (2) Age of the patient at the time of diagnosis of adenocarcinoma of the endometrium, as well as the

TABLE 8. Scheme Treatment of Adenocarcinoma of Endometrium

Stage	Grade	Treatment
IA	1	Total abdominal hysterectomy, bilateral salpingo-oophorectomy + postoperative radium
IA	2-3	Preoperative radium + abdominal hysterectomy,* bilateral salpingo-oophorectomy
IB		Whole pelvic irradiation + total abdominal hysterectomy, bilateral* salpingo-oophorectomy
II		Whole pelvic irradiation + total abdominal hysterectomy,* bilateral salpingo-oophorectomy/or radical hysterectomy and lymphadenectomy
III - IV		Whole pelvic irradiation + Depo-Provera + adriamycin† or bleomycin† + hysterectomy‡
Postoperative		
Depth muscle invasion		<30% = vaginal radium
		>30% + whole pelvic + vaginal radium

*Within one week
†For mixed carcinoma with distant metastasis
‡Whenever medically feasible

degree of myometrial invasion, are important prognostic factors. These two factors should be considered with other features, such as cellular differentiation of the tumor, cervical involvement and the extent of the cancer, in devising a prognostic classification for this type of cancer.

(3) In general, combined irradiation and surgery produce a better result than surgery or radiotherapy alone. This statement applies most specifically for patients with undifferentiated cancer, involvement of the cervix, and myometrial invasion.

(4) Using the prognostic factors, a new protocol for treatment is suggested to improve the results.

References

1. Christopherson WM, Mendez WM, Parker JE, et al: Carcinoma of the endometrium: a study of changing rates over a 15-year period. *Cancer* 27:1005-1008, 1971.
2. Ng AB: Mixed carcinoma of the endometrium. *Amer J Obstet Gynecol* 102: 506-515, 1968.
3. Hirabayashi K, Graham J: Clinical classification of carcinoma of the uterine body. *Surg Gynecol Obstet* 126:75-79, 1968.
4. Jones WE, Kanner HM, Kanner HH, et al: Adenocarcinoma of the endometrium. *Amer J Obstet Gynecol* 113:549-557, 1972.
5. Kottmeier HL: Report presented by the cancer committee to the general assembly of FIGO, New York, April 1970. *Int J Gynecol Obstet* 9:174-179, 1971.
6. Selim MA, So-Bosita JL, Little AB, et al: Carcinoma of the cervix. *Obstet Gynecol* 44:77-83, 1974.
7. Davis EW Jr: Carcinoma of the corpus uteri. A study of 525 cases at the New York Hospital. *Amer J Obstet Gynecol* 88:163-170, 1964.
8. Shah CA, Green TH Jr: Evaluation of current management of endometrial carcinoma. *Obstet Gynecol* 39:500-509, 1972.
9. Sala JM, Del Regato JA: Treatment of carcinoma of the endometrium. *Radiology* 79:12-17, 1962.
10. Frick HC II, Munnell EW, Richart RM, et al: Carcinoma of endometrium. *Amer J Obstet Gynecol* 115:663-676, 1973.
11. Sall S, Sonnenblick B, Stone ML: Factors affecting survival of patients with endometrial adenocarcinoma. *Amer J Obstet Gynecol* 107:116-123, 1970.
12. *US Bureau of the Census, Statistical Abstract of the United States: 1966* (ed 87), Washington DC, 1966.
13. Nahhas WA, Lund CJ, Rudolph JH: Carcinoma of the corpus uteri: a 10-year review of 225 patients. *Obstet Gynecol* 38:564-570, 1971.
14. Park RC, Patow WE, Petty WM, et al: Treatment of adenocarcinoma of the endometrium. *Gynecol Oncol* 2:60-70, 1974.
15. Gusberg SB, Yannopoulos D: Therapeutic decisions in corpus cancer. *Amer J Obstet Gynecol* 88:157-162, 1964.
16. Vongtama V, Kurohara SS, Badib AO, et al: The value of adjuvant irradiation in the treatment of endometrial carcinoma stage I, group I. *Cancer* 25:45-49, 1970.
17. Ng AB, Reagan JW: Incidence and prognosis of endometrial carcinoma by histologic grade and extent. *Obstet Gynecol* 35:437-443, 1970.
18. Badib AO, Kurohara SS, Beitia AA, et al: Recurrent cancer of the corpus uteri: techniques and results of treatment. *Amer J Roentgenol Radium Ther Nucl Med* 105:596-602, 1969.
19. Graham J: The value of preoperative or postoperative treatment by radium for carcinoma of the uterine body. *Surg Gynecol Obstet* 132:855-860, 1971.
20. Cron RS, Hofmeister FJ, Brown RC, et al: Endometrial carcinoma. *Amer J Obstet Gynecol* 70:548-553, 1955.
21. Javert CT: Prognosis of endometrial cancer. *Obstet Gynecol* 12:556-571, 1958.
22. So-Bosita JL, Lebherz TB, Blair OM: Endometrial jet washer. *Obstet Gynecol* 36:287-293, 1970.
23. Abramson D, Driscoll SC: Endometrial aspiration biopsy. *Obstet Gynecol* 27:381-391, 1966.
24. Hofmeister FJ: Endometrial sampling. *J Reprod Med* 4: (2)52-55, 1970.
25. Cheon HK: Prognosis of endometrial carcinoma. *Obstet Gynecol* 34:680-684, 1969.
26. Kurohara SS, George FW 3rd, Vongtama V, et al: Method of staging system construction. *Acta Radiol* 11:65-82, 1972.
27. Renning EL, Javert CT: Analysis of a series of cases of carcinoma of the endometrium treated by radium and operation. *Amer J Obstet Gynecol* 88:171-177, 1964.
28. Lewis BV, Stallworthy JA, Cowdell R: Adenocarcinoma of the body of the uterus. *J Obstet Gynaecol Br Commonw* 77:343-348, 1970.
29. Morrow CP, Di Saia PJ, Townsend DE: Current management of endometrial carcinoma. *Obstet Gynecol* 42:399-406, 1973.
30. Boronow RC: Editorial comment: A fresh look at corpus cancer management. *Obstet Gynecol* 42:448-451, 1973.
31. Badib AO, Kurohara SS, Vongtama VY, et al: Biologic behavior of adenoacanthoma of endometrium. *Amer J Obstet Gynecol* 106:205-209, 1970.
32. Nolan JF, Dorrough ME, Anson JH: The value of preoperative radiation therapy in stage I carcinoma of the uterine corpus. *Amer J Obstet Gynecol* 98:663-674, 1967.
33. Wall JA, Collins VP, Kaplan AL, et al: Adenocarcinoma of the endometrium. *Amer J Obstet Gynecol* 97:787-799, 1967.
34. Heyman J, Reuterwall O, Benner S: The radium hemmet experience with radiotherapy in cancer of corpus of uterus; classification, method of treatment and results. *Acta Radiol* 22:11-98, 1941.
35. Marcial VA, Tomé JM, Ubina J: The combination of external irradiation and curietherapy used preoperatively in adenocarcinoma of endometrium. *Amer J Roentgenol Radium Ther Nucl Med* 105:586-595, 1969.
36. Editor's note. *Obstet Gynecol Surv* 27:804, 1972.
37. Jones HW III: Treatment of adenocarcinoma of the endometrium. *Obstet Gynecol Surv* 30:147-169, 1975.
38. Rutledge F: The role of radical hysterectomy in adenocarcinoma of the endometrium. *Gynecol Oncol* 2:331-347, 1974.



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Common Misconceptions and Pitfalls in Diagnosis and Treatment of Carcinoma of the Cervix

Sergio Perticucci, M.D.
Gunther Ehlers, M.D.

All too often a fatalistic attitude toward early diagnosis of carcinoma of the cervix is accepted by the medical community. Means and methods for successfully eradicating this disease entity do exist today, providing they are fully understood and correctly applied by the general practitioner. Diagnostic procedures should be critically performed according to the needs of each patient.

Defining the extension of invasive cervical carcinoma is a complex task that cannot be accomplished by simply including each patient in a staging system. Therapeutic efforts for the treatment of patients with this type of carcinoma should be guided by highly critical and skilled therapists—persons with a wide range of experience in treating the disease and a thorough knowledge of the many modalities and the equipment available in this field of medicine.

A plea is made for a unified program of therapy and against a "guideline" approach to the problem.

Editor's Note: Every physician should be taking cervical scrapings or endocervical aspirations on examination of female patients. The authors of this article present excellent follow-up procedures in the case of positive pathologic reports.—R.L.M.

IT HAS BEEN STATED THAT death from carcinoma of the cervix is a totally preventable disease entity, and yet, this year alone, 10,000 women will die of this disease in the United States. Although in the last 50 years, stage by stage, there has been a continuous and steady improvement in the survival rates of patients treated for cervical carcinoma, no dramatic breakthrough in the therapy for this disease will compensate for the still large number of patients with already advanced disease who come to medical attention. Much of the current medical literature

addresses itself to very specific and highly technical details related to the treatment of cervical carcinoma. In comparison, less emphasis is given to the continuous education of the nonspecialist or primary care physician to improve the basic skills of preventive medicine as applied to this dreadful disease. It should be obvious that if we are to succeed in eliminating death caused by carcinoma of the cervix, we must improve the dissemination of this basic knowledge to the primary care physicians, who have the best chance to apply it.

Diagnosis

Papanicolaou's Smear. — Recent reports have underscored the relative failure of routine cervical cytology to reach early diagnosis of cervical carcinoma. In some reports, this failure, in the presence of a known neoplasia of the cervix, has been reported as high as 40 percent. However, insufficient attention has been given to the methods employed for obtaining Papanicolaou's smears. It has been well demonstrated that cytology of samples obtained from the vaginal pool has a diagnostic failure rate of as high as 50 percent, while samples obtained by scraping the exocervix have a false negative result in only 15 percent. If an honest effort is made to obtain cytology samples from the endocervical canal, this failure rate further decreases to 8 percent, and to less than 3 percent

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in the case of endocervical aspiration (Table 1).¹ Failure to obtain adequate material for cytologic sampling depends on the little-remembered fact that the transformation zone, or squamocolumnar junction, is a dynamic anatomic entity. Early in life, at the menarche or at premenarchal age, the transformation zone may be well below the external os and sometimes in the upper vagina. With the passing of the years and under the influence of pH, hormonal changes, and pregnancy, the transformation zone tends to gradually progress into the cervical canal. Thus, at the age of maximum risk for cervical carcinoma, anaplastic changes often will occur at the level of or above the external os of the cervix. It, therefore, is essential that the practicing physician, who has the burden of screening the great majority of women, remembers to include endocervic material in his cytologic sampling. This can be best obtained with a variety of instruments, the most successful probably being the Kavorkian endocervical curette and the endocervical aspirator.

The time when the cytologic screening should be initiated depends on the initiation of sexual activity. It is extremely rare that squamos cell carcinoma of the cervix will occur in women who have not had sexual intercourse, however, adenocarcinoma of the cervix can arise in virgins. Therefore, age alone is not a factor in this decision. In addition, if the physician isolates the patients who are high risk for cervical anaplasia and repeats the cytologic screening every six months, the mathematic probability of missing an early cervical neoplasia decreases considerably.

Histologic Diagnosis

Once a positive or suspicious Papanicolaou smear has been reported, the diagnosis of carcinoma must be confirmed histologically. It is undesirable—and indeed an error—to routinely subject these patients to cold conization of the cervix without a prior screening process of less risk and cost. The most successful method of obtaining adequate histologic samples, of course, is by colposcopy; but this method is not available in every community, either because of economic reasons or the lack of an adequately trained colposcopist. Although less adequate, the Schiller stain test will delineate areas which should guide the random biopsies.

There is no reason to proceed with cold conization in the case of an obvious cervical lesion. A simple, small biopsy specimen is usually adequate to confirm the diagnosis. When cold conization of the cervix is performed in the presence of an obvious malignancy, the surgical resection amounts to a true “cut-through” procedure. This procedure is to be condemned because it often results in local complications and may spread a disease which, until that point, could have been considered localized. In addition, the patient is exposed to the unnecessary risks of general anesthesia, blood loss requiring transfusion, and expenses in excess of \$800. Furthermore, local tissue reaction makes subsequent efforts to properly stage such

TABLE 1. False Negative Papanicolaou Smear

Single Slide From	Error %
Vaginal pool	50
Cervical scrape	15
Endocervical sample	8
Os aspiration, scrape	3
Self-irrigation method	20

patients more difficult since local inflammation and infection camouflage the true extent of the tumor in the paracervical and parametrial tissues. Frequently, proper therapy will be delayed, be at the risk of being excessive, or worse yet, be impaired by the infection.

Pathology

In spite of many articles supporting the evidence that dysplasia is part of a continuous process which can ultimately culminate into a full-blown, invasive carcinoma, insufficient recognition has been given to dysplasia as a true, potentially malignant lesion. The concept of cervical intraepithelial neoplasia (CIN) is now well established. Mild, moderate, severe dysplasia and carcinoma in situ are all part of a continuously evolving process that, if left undisturbed, will eventually progress into a frank invasive carcinoma.¹⁻³ The exact percentages of how many dysplasias will eventually follow this course is not known. However, an approximation of 15 percent has been made in the case of mild-to-moderate dysplasia¹⁻³ and 75 percent between severe dysplasia and carcinoma in situ (Table 2).⁴ To neglect a tissue biopsy indicating mild dysplasia as inconsequential, therefore, is a predictable mistake. It is also equally difficult to ascertain the time necessary for this progression. Figures most often accepted are between three and eight years.⁴⁻⁶ It stands to reason that if the process is properly managed at the beginning, the number of disseminated malignancies will eventually decrease to a negligible figure.

The degree of differentiation of the malignancy also is a very important prognostic factor to be considered. In general, the more undifferentiated the carcinoma, the more rapidly it will advance and the sooner it will metastasize via the lymphatics of the pelvis. In the case of adenocarcinoma of the cervix, which represents less

TABLE 2. Malignant Potential of Cervical Intraepithelial Neoplasia (CIN)*

Stage of CIN	Potential
Early (mild-to-moderate dysplasia)	Will progress to invasive carcinoma in 10% to 15% of cases.
Advanced (severe dysplasia and carcinoma in situ)	Will progress to invasive carcinoma in 75% of cases.

*Kottmeier⁴

than 5 percent of all cervical malignancies, this rapid course seems to be more accentuated and probably is not related to sexual activity. Of course, the rarer lesions such as melanomas, sarcomas, and mixed mesodermal tumors, have an even less predictable course; and cytologic detection is even more of a problem.

Therapy

International staging still is the best basic system to simply and consistently describe the extension of any cervical malignancy. From a clinical point of view, however, it is considered by most as a grossly inadequate method to accurately describe cervical lesions and, more importantly, to be used as a base for therapeutic decisions. For example, consider stage IB carcinoma of the cervix. Disregarding the specific degree of differentiation, radical hysterectomy or radical radiation therapy will be equally successful in 85 to 90 percent of the cases. Yet it still is not quite clear why we fail in 10 to 15 percent of the cases.

There are essentially five types of cervical carcinoma for the anatomic clinical point of view.⁷

1. *Exophytic Type*.—This type often extends downward into the vagina; it is of clinical significance because, as a friable polypoid lesion, it can bleed with even slight trauma. Coitus induces bleeding and, therefore, the cervical lesion is most often symptomatic to the patient. Any manipulation during examination, particularly biopsy, may at times produce frightening hemorrhage. The main problem, however, is the difficulty for the examiner to properly define the limits and extension of the sometime-large exophytic mass. It may make the application of a proper central radiation system, such as colpostats and tandem, anatomically difficult (at times impossible) and, therefore, require approach by external radiation first.

2. *Endophytic Infiltrative Type*.—The main characteristic of this lesion is that strains of malignant cells push deep into the surrounding tissues, extending into the endocervix and lower-uterine segment, while the gross appearance is that of a superficial lesion or a small mucosal ulceration. This behavior tends to produce a firm and distorted cervix which can be confused with changes caused by benign disease such as cervical fibroid tumor, endometriosis, or even the "physiologic" large cervix of the multipara. If this type of cervical malignancy is treated by surgery, the surface appearance may be grossly misleading and lead to a less-than-adequate dissection. On the other hand, this lesion also may represent a serious problem for the radiotherapist and possibly influence his judgment erroneously. The tumor tissue volume is larger than in most other varieties and, therefore, requires higher doses of external radiation therapy. In addition, the central radiation as applied by colpostat and tandem often cannot deliver sufficient radiation to reach the outward limits of the disease. This increases the chances of insufficiently treated malignant cells remaining in the bulk of the tumor. In these cases, careful pretreatment evaluation should be performed conjointly

by the radiotherapist and the surgeon. At the end of the radiation therapy, either simple or extended hysterectomy should be considered as part of the integral treatment plan.

3. *Ulcerative or Crater-like Lesion*.—This type most often results from an exophytic lesion which sloughs off after destroying its own blood supply, leaving a central crater which is diffusely ulcerated, often infected, and bleeding. When the central crater involves the endocervical canal, the geometry is distorted and the anatomic situation is such that an intracavitary radiation system may not be adequate. Also, these patients frequently will have a more advanced stage of disease. Therefore, external radiation therapy should precede the application of an internal or intracavitary radiation system.

4. *Pure Endocervical Type*.—As previously cited, the area of origin of the cervical neoplasia, particularly in the older female, often is in the endocervical portion of the transformation zone. Therefore, the malignancy may remain asymptomatic and hidden for a long time. The endocervical lesion also will tend to penetrate deeply into the stroma with early involvement of the blood vessels and lymphatics of the cervix and lower uterine segment. Metastases to the pelvic and para-aortic lymph nodes tend to be more common and to occur earlier. This endocervical growth pattern also will tend to create an area of tumor with poor vascularization; because of lack of adequate oxygenation, these tumor cells may be less responsive to the effect of radiation. As with the endophytic or infiltrative type, a final surgical approach often is required to complement radiation.

5. *Surface Lesions*.—These are perhaps the most favorable of all types of squamous cell carcinoma of the cervix because they tend to involve large areas of the cervix and the endocervix without deep stromal or vascular involvement. However, this type of cervical lesion may extend into the vaginal fornices and, if treated inadequately, will recur in the vagina. Both radical surgery and radiation therapy are very successful treatments for this lesion, provided the radiation therapy plan or the radical dissection encompasses a large portion of the vagina.

Considering this limited discussion of carcinoma of the cervix, it should be obvious that the complexities encountered in properly evaluating these lesions and planning adequate treatment are much more serious than is commonly recognized. Close cooperation between the gynecologic surgeon and the radiotherapist is required to determine the best form of therapeutic management; both should be aware of the subtleties of this disease and be well prepared to cope with the inherent technical problems. All too often, proper evaluation of the patient is further complicated because of previous extensive biopsy procedure or, even worse, partial treatment prior to the patient's referral to a treatment center. It is rather disheartening in this day and age that misunderstandings sometimes still occur between the radiotherapist and the surgeon as to what is the best modality of treatment for

TABLE 3. Operative Findings by Selective Lymphadenectomy in 50 Consecutive Patients with Bulky Squamous Cell Carcinoma-Cervix, July 1971—July 1972, M.D. Anderson Hospital⁷

Stage	Patients Studied No.	Patients with Positive Nodes No.	Bilateral Lymph Nodes Group Involvement	Obturator Hypogastric Complex	External Iliac	Node Groups Involved Common Iliac	Para-aortic	Postoperative Lymphocyst
I	18	6	2	5	1			3
IIA	6	1	1	1				
IIB	16	11	3	8	4	2	1	1
III	10	0	4	7	1	2	4	2
Total	50	27	10					6

a given patient. When this occurs, in our opinion, it usually reflects a lack of understanding of the disease rather than an honest difference of opinion.

Evaluation and Treatment of Advanced Stages

Stages II, III, and IV of cervical carcinoma are each grossly inadequate descriptions for the true anatomic spread of disease. Only recently has serious attention been given to the high incidence of spread of carcinoma to the para-aortic lymph nodes, even in so-called early lesions and those thought to be confined to the pelvis (Table 3).⁷ A standard form of treatment will fail in these cases. Only through meticulous evaluation of every single patient can one hope to assess the true potential for curability and then choose the best modality of treatment. For instance, it now is finally recognized that radiologic evidence of involvement of one or both ureters automatically places these patients in stage III disease. In such cases, a urinary diversion procedure could become necessary prior to radical pelvic irradiation. By the same token, if the rectovaginal septum is massively involved by tumor—even in the absence of frank breakthrough into the rectal mucosa—a diverting colostomy may be necessary prior to initiation of radical radiation treatment. Yet, if the cervical malignancy involves the lower third of the vagina—particularly if it extends into the vulva—its clinical behavior will be worse because of early spread to the inguinal nodes as a vulvar carcinoma plus the usual lymphatic routes of spread of the more localized cervix cancer. Therefore, a completely different approach such as total exenteration should be considered, if feasible.

Radical Radiation Therapy

Radical radiation treatment of carcinoma of the cervix consists of two distinct components, each with a different purpose. It usually entails the combination of external pelvic irradiation, with teletherapy from a cobalt 60 or an x-ray source, and internal or intracavitary irradiation of the uterus and vagina through specially designed applicators loaded with sealed sources of radioactive materials (radium, cobalt 60, or cesium 137). These two types of radiation are delivered in some order of sequence over a period of several weeks.

Ideally, the entire course of treatment should be given at one institution and by the same radiation therapist. Performance of the intracavitary irradiation by one physician at one institution with subsequent referral of the patient to another institution for external pelvic irradiation, as sometimes practiced, is not in the best interest of the patient and should be discouraged. Such practice can lead to unnecessary complications in terms of either inadequate disease control or an excessive complication rate. Considering the variety of internal applicators in use, the differences in training background and personal experience of individual radiation therapists, and the different techniques and dosimetric factors involved, it should be apparent that the internal and external radiation should best be given by the same specialist. Fragmentation of responsibility here may constitute an unwarranted hazard to the patient and adversely affect the final result of the treatment.

Preceding discussion has pointed out that adequate management of carcinoma of the cervix is not always a simple matter or a "guidebook-type" treatment. Treatment should be tailored to the clinical and anatomic situation of each individual patient. Based on specific geometric considerations and taking into account the anatomic situations at hand, the radiation therapist will initially formulate an overall plan of treatment and then carry it out unless unforeseen circumstances impose a change in strategy.

Administering the internal irradiation at one institution because an applicator system with radioactive sources is available, even though referral of the patient to another institution for external pelvic irradiation is anticipated, does not constitute a valid reason for this practice. In our opinion, such a "treatment-splitting" practice may be more unethical than fee-splitting.

Experience has shown that detailed and reliable records of internal radiation administered elsewhere are not always available to the radiation therapist assigned the task of administering the external pelvic irradiation. Thus, he finds himself in the difficult position of having to "build his treatment on a foundation" about which he has little information. This type of therapy seldom yields the best results obtainable under more favorable condi-

tions. For this reason, we strongly suggest that it is preferable that all radiation therapy be administered in an institution with adequate facilities and competent personnel available to perform the task.

References

1. DiSaia PJ, Morrow CP, Townsend DE: *Synopsis of Gynecologic Oncology*. New York, Wiley, 1975.
2. Fox CH: Biologic behavior of dysplasia and carcinoma in situ. *Am J Obstet Gynecol* 99:960-974, 1967.
3. Richart RM, Barron BA: A follow-up study of patients

with cervical dysplasia. *Am J Obstet Gynecol* 105:386-393, 1969.

4. Personal communication, August 2, 1968, as quoted from Koss LG: Concept of genesis and development of carcinoma of the cervix. *Obstet Gynecol Surv* 24:850-860, 1969.
5. Boyes DA, Worth AJ, Fidler HJ: The results of treatment of 4,389 cases of preclinical cervical squamous carcinoma. *J Obstet Gynaecol Br Commonw* 77:769-780, 1970.
6. Green GH: Invasive potentiality of cervical carcinoma in situ. *Int J Gynecol Obstet* 7:157-171, 1969.
7. Rutledge F, Boronow RC, Wharton JT: *Gynecologic Oncology*. New York, Wiley, 1976.

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A regular meeting of the Council of the Ohio State Medical Association was held Saturday, September 25, and Sunday, September 26, 1976 at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Dr. C. Edward Pichette); Drs. P. John Robechek, Cleveland, Chairman, Ohio Delegation to the AMA, John H. Ackerman, Columbus, Director, Ohio Department of Health; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Freeman, Mrs. Wisse, Mrs. Dodson, and Mrs. Jacobson of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Dr. W. J. Lewis and Dr. Pichette); Dr. Robechek, Mr. Pohlman, Dr. William A. Newton, Columbus, Professor, Department of Pediatrics and Pathology, The Ohio State University College of Medicine; Dr. Albert F. LoBuglio, Columbus, College of Medicine, OSU; Mr. Edward A. Lentz, Columbus, President, Medical Advances Institute; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Houser, Holcomb, Mrs. Dodson, Ms. Doll, and Mrs. Jacobson of the OSMA Staff.

MINUTES APPROVED

The following minutes **were approved**: meetings of Council held July 10-11 and August 1, 1976 in Columbus, and a meeting held by conference call on August 24.

STATEWIDE HEALTH COORDINATING COUNCIL

By official action, the Council endorsed Carl E. Wasmuth, M.D., Cleveland, for a place on the (Ohio) Statewide Health Coordinating Council.

MEMBERSHIP

Mrs. Wisse reported that membership as of September 12, 1976 equalled the membership as of December 31, 1975. Even though this reaching of year end totals showed an increase of 144 in exempt members, the opportunity for substantial OSMA membership gain is indicated.

The Council expressed concern due to the lag in AMA membership figures and discussed programs to improve this record.

FISCAL

The minutes of the September 24, 1976 meeting of the Committee on Auditing and Appropriations were presented by Dr. Rinderknecht and **were approved**.

A list of expenses incurred on Professional Liability Task Force projects **was approved** for payment.

The Council **approved** the establishment of a Department of Continuing Medical Education within the OSMA structure and ratified the appointment of Mrs. Gail Dodson as its Director.

The Department will encompass the activities of both the Committee on Scientific Work and the Commission on Medical Education.

The appointment of D. Brent Mulgrew, Esq., as Director of the Department of State Legislation was confirmed. He will succeed David L. Rader, who has announced his resignation as Director to become Administrative Vice President of The Physicians Insurance Company of Ohio.

Also confirmed was the appointment of Douglas R. Houser as Assistant Director of the Department of Continuing Medical Education.

AMERICAN MEDICAL ASSOCIATION

Dr. P. John Robechek and Mr. Campbell discussed plans for the meeting of the American Medical Association in Philadelphia, December 4-7, 1976.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

OSMA Annual Meeting

Mrs. Dodson presented the minutes of the Committee on Scientific Work, covering meetings of July 31 and September 18, 1976. **Approval** of the minutes included authorization to the Committee to explore co-sponsorship with pharmaceutical companies of Category I programs. The format for the 1977 Annual Meeting and a theme for the meeting **were approved** by official action.

The first session of the House of Delegates was scheduled for 7:00 PM Sunday, May 15, 1977, and the final session for 3:30 PM Wednesday, May 18.

The subjects for Saturday program proposals in the areas of "The Art of Negotiating," "Public Speaking Training Courses," and "The Ethical Dilemma of Crisis Medicine" **were approved**. A Monday afternoon General Session updating the developments concerning The Physicians Insurance Company of Ohio was recommended by the Council.

Committee on Scientific Work

Mrs. Dodson reported on the July 31 and September 18 meetings of the Committee on Scientific Work (see above).

(continued on page 682)

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The September 18 minutes contained a critique on the OSMA Alaskan Category I Seminar. The Council accepted a recommendation that any future Category I travel programs be considered with the stipulation that all arrangements be made by OSMA Staff. The Council also **approved** the arrangements for a Regional Category I Continuing Medical Education Session to be held February 12 and 13, 1977 at Ohio University Inn, Athens, under the jurisdiction of the Committee on Scientific Work.

OSMA Sections and Specialty Society Officers

Mrs. Dodson presented for the information of the Council a review of the September 1, 1976 meeting of the OSMA Sections and Specialty Society Officers.

Commission on Medical Education

The minutes of the September 15, 1976 meeting of the Commission on Medical Education were presented by Mr. Houser and were received for information.

Mr. Houser indicated that 27 institutions had been accredited and 187 physicians had received the Ohio Physician's Recognition Award. He indicated that conferences are being held with the Ohio State Medical Board to assist the Board in clarifying its duties with regard to the certification of continuing medical education credits by physicians.

Other CME Activities

Mrs. Dodson reported on the workshop "Establishing Yourself in Medical Practice," held September 14-15, cosponsored by the AMA, the OSMA, and Conomikes Associates of Los Angeles. She reported that the evaluation of the program by the 23 doctors participating was uniformly excellent. The Council **approved** a similar two-day workshop for 1977 and four, one-half day seminars on "Financial Management" for that year.

MEDICAL ADVANCES INSTITUTE/ PEER REVIEW SYSTEMS

The minutes of the September 16, 1976 Board of Di-

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rectors meeting of MAI were presented for information.

Mr. Edward A. Lentz, President of Medical Advances Institute, addressed the Council concerning the Ohio Health Data Corporation.

OHIO MEDICAL INDEMNITY, INC.

Mr. Gillen reviewed minutes of the Ohio Medical Indemnity, Inc. Executive Committee meeting of August 25, 1976.

OHIO FOUNDATION FOR MEDICAL CARE

Mr. Rader presented for the information of the Council a report on the fiscal aspects of the dissolution of the Ohio Foundation for Medical Care.

PHYSICIANS INSURANCE COMPANY OF OHIO

The minutes of the Ad Hoc Committee of Council to

The Physicians Insurance Company of Ohio for July 14 and August 11 were presented to the Council for information. In addition, the Council received for information minutes of a meeting of the Ad Hoc Committee held by telephone conference call on August 24, 1976.

Mr. Rader discussed a meeting of the Ad Hoc Committee held September 24, 1976.

Dr. Wells proposed a series of district meetings throughout the state, which would offer the opportunity for two-way communications with the membership, concerning The Physicians Insurance Company of Ohio. The proposal was adopted and the Executive Director assigned the Field Service Department to coordinate the meetings.

On a motion by Dr. Lieber, seconded by Dr. Hogg, the Council voted to commend Mr. Rader for the excellence of his work with the OSMA and to wish him well in his position as Administrative Vice President of The Physicians Insurance Company of Ohio.

(continued on page 684)

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COMMITTEE REPORTS

Task Force on Professional Liability

Mr. Campbell presented the minutes of the July 14 meeting and a report of the July 28 meeting of the Task Force on Professional Liability.

A review of the returns from the professional liability suit questionnaire was presented by Mrs. Jacobson as a progress report. Mrs. Jacobson indicated that a 39 percent rate of return had been achieved to date.

Committee on Workmen's Compensation

The minutes of the July 21 meeting of the Committee on Workmen's Compensation were presented by Mr. Gillen and were **approved**, with a minor amendment.

The major thrust of the meeting involved Sub. S.B. 545 of the Ohio General Assembly, which would restructure the administration of the Bureau of Workmen's Compensation. The minutes contained a number of suggestions with regard to the provisions of the bill which were for the guidance of the OSMA State Legislative Department during consideration of the measure by the Ohio General Assembly.

Committee on Health Manpower

Mr. Clinger reported on the meeting of the Committee on Health Manpower held July 28, 1976. The Council **approved** the minutes and the recommendation for a Medical/Nursing Liaison Committee consisting of representatives of several organizations concerned with medical and allied medical education and delivery of health care. A one-day "Think Session" of representatives of those organizations with regard to nursing programs in Ohio was also **approved**.

The minutes, as a whole, were accepted.

Committee on Maternal and Neonatal Health

The minutes of the August 1, 1976 meeting of the Committee on Maternal and Neonatal Health were presented by Mrs. Dodson and were accepted for information.

Committee on Government Medical Care Programs

Mr. Gillen presented the minutes of the August 4 meeting of the Committee on Government Medical Care Programs. The minutes, as a whole, were **approved**, and the Council reiterated its existing policy of peer review as applied to prescribing practices and voted to offer to assist the Ohio Department of Public Welfare in the development of criteria for selection of cases to be referred for review.

An extensive discussion of the fraud investigation conducted by the U.S. Department of Health, Education,

and Welfare and the Ohio Department of Public Welfare was contained in the minutes and the Council was updated on the conduct of the investigation by those agencies.

Committee on School Health

Mr. Clinger presented the August 25, 1976 minutes of the Committee on School Health. Contained in the minutes was a recommendation that OSMA have reintroduced in the Ohio General Assembly legislation similar to S.B. 498, in the 110th Ohio General Assembly, authorizing contraceptive and pregnancy advice and treatment for minors without parental consent. The recommendation was adopted (Dr. Gaughan dissenting).

The Council **approved** the endorsement of the Children's Postural Screening Program, revision of "Suggested Procedures for School Medical Emergencies," and the transmittal to the Superintendent of Public Instruction, for distribution to superintendents and principals of Ohio elementary and secondary schools, copies of a news release on immunization prepared by the OSMA Media Relations Section of the Public Relations Department.

Committee on Emergency and Disaster Medical Care

Mr. Houser discussed a meeting of the Committee on Emergency and Disaster Medical Care held September 18, 1976.

Council Medical Services Review

Dr. Morgan and Mr. Campbell presented a report of the Council Medical Services Review Committee which met September 24, 1976. A number of cases were presented for the information of the Council.

Committee on Public Relations

Mr. Edgar reported on a meeting of the Committee on Public Relations, held June 2, 1976. The Council accepted the report as a progress report on the work of the Committee and the Department.

The exploration of the possibility of syndicating *Your Doctor Reports* was **approved**.

A proposal for the acquisition of a radio and television communication facility was referred to the Auditing and Appropriations Committee without discussion.

By official action, all the Council deleted a paragraph which would have required that the public relations, public information, and public education of the malpractice program be transferred from the Task Force on Professional Liability to the Department of Public Relations. The remainder of the report was accepted.

Building Committee

In accordance with a recommendation from Dr.

James L. Henry, Chairman of the Building Committee, that committee was officially dissolved, and any remaining duties having to do with maintenance, upkeep, management policies, etc., were assigned to the Committee on Auditing and Appropriations.

PR WORLD CONGRESS

Mr. Edgar reported on the PR World Congress, held August 10-14 in Boston. Mr. Page pointed out that he had been advised by the AMA that during the meeting, Mr. Edgar was elected a member of the Executive Committee of the Health Section of the Public Relations Society of America and that the Health Section is the third largest section of the Society. The Council commended Mr. Edgar for his participation in the PRSA activities and for his election to this office.

COUNCILOR REPORTS

The Councilors reported on activities in their respective districts.

FEDERAL LEGISLATION

Mr. Edgar reported on current federal legislation. He advised that the Health Manpower Act was modified considerably due to the activities of the AMA, selected state medical associations and Senator Taft of Ohio.

The Council voted to support in principle the anti-fraud mechanisms proposed for inclusion in the Department of Health, Education, and Welfare, and as exemplified by the AMA Medicaid-Medicare anti-fraud proposal.

Mr. Edgar announced that the AMA is presently rewriting the Medigap Bill and suggestions for changes would be in order at this time.

STATE LEGISLATION

A review of current state legislative developments, including the Workmen's Compensation legislation and Medicaid amendments were presented by Mr. Mulgrew. Mr. Mulgrew was commended by the Council for his diligence in weeding out many ill-advised proposals in this legislation prior to passage.

CONSTITUTION AND BYLAWS

The Council **approved** amendments to the Constitution and Bylaws of the Stark County Medical Society, with the advice that removal of the honorary membership category should be accomplished in the Bylaws, as well as in the Constitution.

Amendments to the Summit County Medical Society Constitution and Bylaws **were approved**, with the excep-

tion of a provision of waiver of license as a requirement for membership. Council instructed legal counsel to discuss this matter with the Society.

FIELD SERVICE

Mr. Holcomb presented a report on field service visits since the July 10-11 meeting of the Council.

The Council **approved** a two-day seminar on negotiations to be coordinated by the Field Service Department, February 26-27, 1977.

MEDICAID PROVIDER AGREEMENT

Mr. Gillen discussed problems incurred with the Medicaid "Provider Agreement."

The Council expressed the opinion that Medicaid beneficiaries in need of medical care must receive medical care. It was the instruction of the Council that each member of the OSMA be informed of the current situation with respect to participation in the Medicaid program and that each member be made aware of the options available to him and the likely consequences of pursuing each option.

HEALTH DIRECTOR'S REPORT

Dr. Ackerman addressed the Council with regard to the current status of the A/New Jersey influenza immunization program. He indicated that there is a relative shortage of monovalent vaccine at this time, but that supplies of bivalent are relatively adequate.

He reported that the surveillance and control program against St. Louis Encephalitis has been successful, with only four cases reported this year. He expressed the hope that Ohio can be free of the disease next year.

He expressed appreciation to the Ohio Public Health Council for its work, and commended Dr. Dorner, who is a member of the Council.

AD HOC COMMITTEE ON HOUSE VOTING

The Council authorized the President to appoint an Ad Hoc Committee to develop a proposed policy for the consideration of the House of Delegates on the subject of "single shot" voting for candidates standing for election by the House.

The President appointed Dr. Dorner, Chairman; Dr. Diller, Dr. Pfahl, and Dr. Rinderknecht.

"SECOND OPINION" COMMITTEE

The Council authorized the President to appoint an Ad Hoc Committee to study the previous research and

(continued on page 686)

current developments with regard to "second opinion" surgical consultation. The President appointed Dr. Hogg, Chairman; Dr. Morgan, Dr. Pfahl, and Dr. Williams.

MEDICAL SERVICES REVIEW PROCEDURES

OSMA procedures for Medical Services Review were discussed and it was the Council's decision to continue for the time being the present review policies and procedures.

DR. GAUGHAN NOMINATED FOR PRESIDENT-ELECT

The Council received a communication, dated September 20, 1976, from the Academy of Medicine of Cleveland, nominating John J. Gaughan, M.D., Cleveland, Fifth District Councilor, for the office of President-Elect of the OSMA.

OSU COMPREHENSIVE CANCER CENTER

William A. Newton, Jr., M.D., Chairman of the OSMA Committee on Cancer, and Dr. Albert F. LoBuglio, M.D., Deputy Director of the OSU Comprehensive Cancer Center, discussed a request for OSMA support of a Developmental Cancer Control Support Grant application to the Department of Health, Education, and Welfare.

The Council **approved** a motion to support the grant application, in principle, contingent on approval (by telephone poll) of the OSMA Committee on Cancer, and indicated that a communication to the Department of Health, Education, and Welfare not only approve this grant in principle, but also approve, in principle, additional Comprehensive Cancer Centers for other areas of Ohio.

ADJOURNMENT

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page,
Executive Director

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LEVERAGED TAX SHELTER FOR 1976: Maximum tax benefits for fiscal and calendar year. Principals and tax counsel invited. Contact: Medivest, Inc., Venture Building, 4620 Spring Grove Avenue, Cincinnati, Ohio 45232. Telephone: 513/681-8000. (See Medivest ad this issue.)

ASSOCIATE WANTED: Cincinnati Professional Corporation seeks associate. Openings available in emergency rooms and medical centers doing family practice and industrial cases. Medical Health Services, Inc., 5002 Ridge Ave., Cincinnati, Ohio 45209. Telephone: 513/631-0200.

GENERAL SURGERY RESIDENCY PROGRAM: New, five-year program reactivated at Lutheran Medical Center, Cleveland, Ohio. Candidates must be graduates of American or Canadian Schools of Medicine. Those wishing to apply for positions at the second- and third-year levels, beginning in July 1977, may receive information from: Joseph Avellone, M.D., Director of Surgery, Lutheran Medical Center, 2609 Franklin Blvd., Cleveland, Ohio 44113.

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PHYSICIAN, Board Eligible in Pediatrics and Preventive Medicine, desires position in central or northeast Ohio. Prefers position with a health department which would include some clinical pediatrics. Contact: Peter D. Rogers, M.D., M.P.H., Cedar Hill North, 651 Pineridge, Raleigh, North Carolina 27609. Telephone: 919/829-3419.

PSYCHIATRIST: STARTING SALARY \$35,000-\$45,000. Prefer two years experience in Community Psychiatry. To carry treatment and supervisory responsibilities in a progressive and growing community mental health center. Medical staff includes two full-time psychiatrists and a complement of psychiatric consultants. A reasonable work pace and pleasant facilities. Enjoy with us the benefits of living and working in a scenic, rural community on the Ohio River, with the added advantage of being only 30 minutes from downtown Cincinnati, Ohio. Contact James F. Jones, Executive Director, Community Mental Health-Mental Retardation Center, Inc., 285 Bielby Road, Lawrenceburg, Indiana 47025.
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RADIOLOGIST needed by 40-physician, multispecialty, group practice in southeastern Ohio. Paid liability insurance, excellent benefits, salary negotiable. Contact: Robert E. Daniel, Administrator, 614/446-5187, or write Holzer Medical Center Clinic, P.O. Box 344, Gallipolis, Ohio 45631.

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FAMILY PRACTITIONER needed for Branch Clinic of 40-physician, multispecialty, group practice clinic located in southeastern Ohio. Branch Clinic is under construction now with operations to begin in early 1977. Excellent benefits, paid liability insurance, salary negotiable. Contact: Robert E. Daniel, Administrator, Holzer Medical Center Clinic, P.O. Box 344, Gallipolis, Ohio 45631. Phone: 614/446-5187 collect.

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CHILD HEALTH ASSOCIATE (Pediatric Physician Assistant): Graduate of university program with over five years experience in office, hospital and satellite clinic practice, plus one year as instructor of pediatrics in university health assistant program, is willing to relocate to assist G.P., pediatrician or group. National cert. and reg. Exceptional credentials. Available December. Reply Box 777 c/o Ohio State Medical Journal.

(Editor's Note: The Journal presents the above classified advertisement to its readers as an announcement of the physician assistant and assumes no responsibility for the statements made.)

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DECEMBER 1976

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Index Issue

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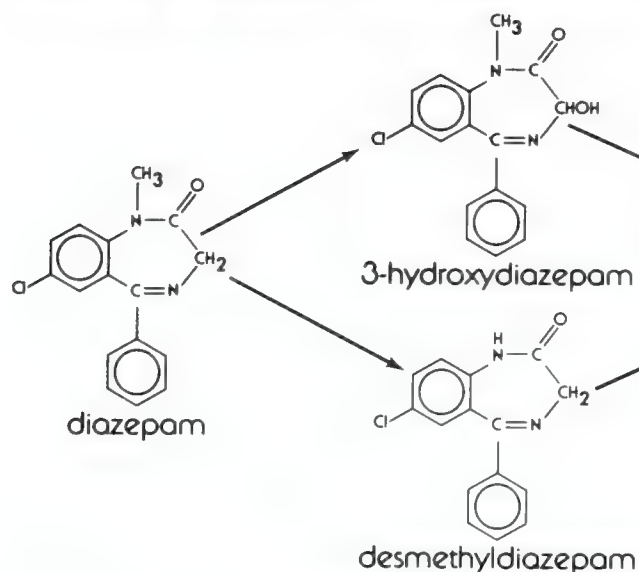


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COVER: The officers, councilors, and staff of The Ohio State Medical Association take this opportunity to wish all a Most Joyous Holiday Season. (Photograph by D. Brent Mulgrew. Shot at 10 AM in Sharon Woods Metropolitan Park, Cincinnati, Kodachrome F-11, 125.)

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Tax Reform Act of 1976

Affects Physician Filings

During the summer of 1976, the Congress of the United States passed a complicated Tax Reform Act which affects tax filings for the taxable year 1976 and years to follow. Some portions of the bill go into effect as of the 1976 tax filing, while other aspects begin in 1977 or 1978. There are a few items that are to continue only for a trial period and then will be studied to determine future use.

With the assistance of Larry Girvin of the Professional Practice Management Department of the Columbus Bureau of Medical Economics, *The Journal* herein presents a review of the changes most likely to affect physician tax filings. This article is offered to give the reader an acquaintance with areas of the Tax Reform Act of 1976 in which changes have been made; therefore, it can, in no way, replace the advice of the physician's personal tax consultant.

This article is organized with changes in the tax rulings grouped by the year in which they take effect.

Rulings Effective 1976 Taxable Year

Business Use of Home

A taxpayer no longer may deduct any expenses attributable to the use of his home for business purposes unless they are attributable to the portion of the home used exclusively and on a regular basis as (1) his principal place of business or (2) a place of business which is used by patients, clients, or customers in meeting or dealing with the taxpayer in the normal course of business.

"Place of business" includes a separate structure which is not attached to a taxpayer's residence but is used in connection with his trade or business. In the case of an employee, no deductions are permitted unless he meets the above condition and the use is for the convenience of his employer.

If a taxpayer meets these requirements, he must limit the deductions for the business use of home to an amount equal to or less than the gross income derived from the business use less the deductions which are allowed without regard to their connection with the taxpayer's trade or business (ie, mortgage interest).

Capitalization and Amortization Of Interest and Taxes During Real Property Construction Period

New provisions in the Act affect nonresidential real estate where the construction period begins after December 31, 1975. However, for 1976 only, 50 percent of the construction period interest and taxes need be capitalized.

Construction period interest and taxes are to be capitalized in the year in which they are paid or incurred and amortized over a ten-year period. A portion of this amount capitalized may be deducted for the taxable year in which paid or incurred. The balance must be amortized over the remaining years in the amortization period beginning with the year in which the property is ready to be placed in service or is ready to be held for sale.

Child and Dependent Care Expenses

Beginning in taxable years after 1975, child and dependent care expenses are to be handled as a tax credit in an amount equal to 20 percent of the employment-related expenses paid by an individual to enable him or her to be employed. The credit may be applied to the income tax for the year reduced by (1) general tax credit, (2) credit for the elderly, (3) foreign tax credit, (4) investment credit, (5) WIN credit, (6) political contributions credit, and (7) credit for purchase of a residence.

Credit may be claimed for the care of any of the following individuals: (1) a dependent of the taxpayer under age 15 years for whom the taxpayer may claim a dependency exemption (This applies except in the case of a divorced or separated taxpayer having custody of a child for more than six months in a taxable year. The taxpayer may then qualify for the credit even though he may not claim the dependency exemption.); (2) any other dependent of the taxpayer who is physically or mentally incapable of caring for himself and for whom the taxpayer contributes more than half his support; or (3) the taxpayer's spouse if he or she is physically or mentally incapable of caring for himself or herself.

Employment-related expenses include expenses for household services and for the care of a qualifying individual. Services outside of the home qualify only if they

(continued on page 692)

Tax Reform Act *(continued)*

involve the care of a child under age 15 years. Generally, payments to a close relative do not qualify unless the taxpayer or his spouse is not entitled to a dependency exemption for the relative and the relative's services constitute employment for Social Security purposes.

The credit, equal to 20 percent of employment-related expenses, may not exceed \$400 if one qualifying individual is involved (20 percent of \$2000) or \$800 if more than one qualifying individual is involved (20 percent of \$4000).

Limitation on Deductions

(1) Amount of Risk

The amount of any loss which may be deducted in connection with an activity cannot exceed the aggregate amount with respect to which the taxpayer is at risk in the activity at the close of the taxable year. The limitation applies to the following activities: (1) farming (except operations involving trees other than fruit or nut trees); (2) exploring for, or exploiting, oil and gas resources; (3) holding, producing, or distributing motion picture films or video tapes; and (4) equipment leasing.

The limitation applies to all taxpayers other than corporations which are not tax-option corporations.

A partner's adjusted basis in the partnership shall not include any portion of any partnership liability with respect to which he has no personal liability. Partnerships engaged in real estate investments (other than mineral property) are excluded.

(2) Nonbusiness Interest

Interest on investment indebtedness is limited to \$10,000 per year plus the taxpayer's net investment income. No offset of investment interest is permitted against capital gain income. An additional deduction of up to \$15,000 per year is permitted for interest paid in connection with indebtedness incurred by the taxpayer to acquire the stock in a corporation, or a partnership interest, where the taxpayer, his spouse, and his children have (or acquire) at least 50 percent of the stock or capital interest in the enterprise.

Any interest deduction disallowed under these rules may be deducted in future years with unlimited carry-over.

Recapture of Depreciation On Real Property

The Tax Reform Act provides for the recapture of all post-1975 depreciation on residential real estate in excess of straight line, in the same manner as is presently the case for non-residential real estate.

In the case of government subsidized housing, full recapture of post-1975 depreciation for the first 100 months (8 $\frac{1}{3}$ years) is allowed with a phase-out of the amount recaptured during the second 100 months. There is no recapture thereafter.

Vacation Home Rental

Deductions on the rental of vacation homes have been limited by the Tax Reform Act. These limitations apply to individuals, tax-option corporations, and trusts, estates, and partnerships.

Minimum Rental Use: If the home is rented for less than 15 days during the taxable year, no deduction attributable to such rental are allowable. However, other allowable deductions, such as interest on a mortgage, are not affected. In addition, income derived from the rental is not to be included in gross income.

Minimum Personal Use: If personal use of the home does not exceed 14 days or 10 percent of the number of days for which the home is rented at fair rental, deductibility of expenses will be tested under the "hobby loss" provisions not the new rules.

Personal Use Limitation: If the vacation home use falls into *neither* of the above categories (ie, rented for more than 15 days *and* personal use exceeds 14 days or 10 percent of days home was rented), the deductions attributable to the rental activity are limited. The amount of the rental deduction may not exceed the amount equal to the difference between the gross income derived from the rental activity and the deductions otherwise allowable for the property (ie, interest, taxes).

The order in which these deductions are to be taken in applying the limitation is unchanged by the new regulations: (1) taxes and interest, (2) operating expenses attributable to the rental activities (except as noted in #3), and (3) depreciation and other basis adjustment items.

Rulings Effective 1977 Taxable Year

Alimony Payments

Alimony payments are deductible from gross income in arriving at adjusted gross income. This ruling differs from previous years during which alimony payments were treated as an itemized deduction. Therefore, the change in the tax law means that a taxpayer will be able to deduct his alimony payments and also use either the standard deduction or itemize his other nonbusiness deductions.

(continued on page 694)

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Tax Reform Act *(continued)*

The other tax rules concerning alimony remain the same including the fact that the recipient of alimony must include it in income and pay tax on it.

Capital Assets

(1) Holding Period

The holding period has been increased from "more than six months" to "more than nine months." The holding period requirements for commodity futures contracts remain unchanged.

(2) Loss Deduction

A net capital loss for the year may offset up to \$2,000 of ordinary income for the taxable year 1977.

Dependency Exemptions For Divorced Parents

Under the new tax regulations, the noncustodial parent must provide at least \$1,200 in child support per year for each child in order to be entitled to the exemption. If the noncustodial parent provides such support, the custodial parent must prove that he contributes more than this amount in order to claim the deduction. This rule does not affect cases in which a decree of divorce or separate maintenance specifies which parent is to take the dependency exemption.

Foreign Conventions

Foreign conventions held after December 31, 1976 are affected by this rule. Generally, no deduction will be allowed for expenses incurred by an individual in attending more than *two* foreign conventions in any taxable year. The amount of expenses that can be deducted for transportation and subsistence for the two allowable conventions is limited.

Transportation expenses are allowed only if 50 percent or more time is devoted to business-related activities during the trip. Conventions must schedule six hours to count as a full day and three hours to count as a half day. In addition, a signed statement from the convention must state that the physician attended two-thirds of the total hours.

Expenses are limited to the per diem rate established for United States civil servants.

"Foreign conventions" are defined as any convention, seminar, or similar meeting held outside the U.S., its possessions, and the Trust Territory of the Pacific.

Group Legal Services Plan

An employer may establish a written plan to provide prepaid personal legal services for his employees and their spouses and dependents. Employer contributions to the plan can be paid only through one or a combination of the following methods: (1) direct prepayments, (2) insurance funding, (3) special trust, and (4) exempt organization. Contributions to the plan by the employer must be excluded from the gross income of the employee, his spouse or dependents, as must be the value of legal services provided under the plan.

This provision of the Tax Reform Act is effective for a trial period of five taxable years beginning after 1976 and ending before 1982.

Individual Retirement Accounts For Homemakers Authorized

The Individual Retirement Savings (IRA) provisions have been expanded to permit a limited deduction from gross income for cash contributions to an IRA covering a nonworking spouse. The deduction must be equal to one of the following, whichever is smaller: (1) 15 percent of the compensation included in the working spouse's income for the taxable year; (2) \$1,750; or (3) twice the amount contributed to the individual retirement savings arrangement of the spouse for whose benefit the smaller amount was contributed.

No deduction is allowed for the taxable year during which either spouse reaches age 70½ years or any future taxable years.

If the taxpayer and his spouse have taxable years ending on different dates, the taxpayer's spouse must have received no compensation during the taxable year ending within the taxpayer's taxable year in order to qualify for this plan.

Finally, no contributions to a joint IRA or separate IRAs are deductible if, during any part of the taxable year, either spouse was an active participant in one of the following plans: (1) a qualified plan under Code Sec. 401 (a); (2) an annuity plan under Code Sec. 401 (a); or (3) a qualified bond purchase plan under Code Sec. 405 (a). Also, contributions made by an employer for a tax-sheltered annuity will make contributions to an IRA nondeductible.

Moving Expenses

The mileage limitation as regards the distance between the taxpayer's new principal place of work and his former residence has been reduced from 50 to 35 miles. Thus, the new job location must be at least 35 miles further from the former residence than was the old job location in order for the expenses of the move to be deductible. (Ie, if the distance between the old

residence and the former place of employment was 5 miles, the new place of employment must be at least 40 miles from the old residence.)

The maximum dollar limitation on the deductions for expenses of househunting trips, temporary quarters, and qualified residence sale, purchase, or lease expenses has been increased to \$3,000 from \$2,500. However, no more than \$1,500 can be for expenses of househunting trips and temporary quarters. If both spouses begin work at the new location, the limitation applies to their combined expenses on a joint return. On separate returns, a \$1,500 limit applies to each with the househunting trips and temporary quarters expenses being limited to \$750.

Unchanged are the rules allowing deduction from gross income of actual travel expenses enroute between residences and the cost of moving household goods and personal effects. Neither expense is subject to a maximum dollar limitation.

Removal of Barriers for Handicapped or Elderly Persons

A special deduction for individuals and corporations to promote the removal of architectural and transportation barriers to the handicapped and elderly is provided in the new tax rules. This deduction is effective for taxable years beginning after 1976 and ending before 1980. Expenses for the removal of architectural and transportation barriers may be treated as deductible expenses in the year paid or incurred. Previously, the expenses had to be capitalized. The maximum deduction for any taxable year is limited to \$25,000.

Physicians should keep this rule in mind should they do any building or remodeling of their offices.

Sale of Personal Residence

The base amount of the once-in-a-lifetime exclusion for the gain from the sale of one's home has been increased from \$20,000 to \$35,000 for a taxpayer age 65 years or older.

Rulings Effective 1978 Taxable Year

Capital Assets

(1) Holding Period

The holding period has been increased from "more than nine months" (see "Capital Assets"— 1977) to "more than one year." The holding period requirements for commodity futures contracts remain unchanged.

(2) Loss Deduction

A net capital loss for the year may offset up to \$3,000 of ordinary income for taxable years beginning in 1978.

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(Editor's Note: Items for this calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed below.)

The Ohio University Inn, Athens, is the site for a Category I scientific program sponsored by the OSMA Committee on Scientific Work. The event, which will be held February 12 and 13, will feature the Advanced Life Support Program. This program will cover two days and will be conducted by the American Heart Association. In addition, three postgraduate courses will be offered. A course on antibiotics will be held on Saturday morning, February 12, under the direction of Martin McHenry, M.D., of the Cleveland Clinic Foundation. The Saturday-afternoon course, "Electrolytes and Acid Base Disturbances," will be conducted by Lionel R. King, M.D., Cincinnati. Louis Rakita, M.D., of the Cleveland Metropolitan General Hospital, is the director of the Sunday-morning course on cardiology. Any questions regarding this Category I program should be directed to the OSMA Department of Continuing Medical Education.

Periodic Programs

ANESTHESIA 800 SERIES: Saturdays, 8:30 AM; Institute of Pathology, CWRU Campus, Cleveland; sponsor: Department of Anesthesiology, CWRU School of Medicine, 2 credit hours per session; contact: Dr. J. S. Gravenstein, Department of Anesthesiology, Lakeside Hospital, Cleveland 44106, phone: 216/791-7300.

ANESTHESIOLOGY CONFERENCE: Wednesday, 4:15 PM; Anesthesia Conference Room, 7th Floor, Lakeside Hospital, Cleveland; sponsor: Department of Anesthesiology, CWRU School of Medicine; 1 credit hour per session; contact: Helmut F. Cascorbi, M.D., Department of Anesthesiology, Lakeside Hospital, Cleveland 44106, phone: 216/791-7300.

CLEVELAND ORTHOPEDIC CLUB: 1st Saturday each month, except February, 9 AM; Auditorium-Museum of Natural History, Cleveland; sponsor: Division of Orthopaedic Surgery of CWRU School of Medicine; 3 credit hours per session; contact: Dr. Barry Friedman, Department of Surgery, Mt. Sinai Hospital, Cleveland 44106, phone: 216/795-6000.

CLINICAL FACULTY CONFERENCE: All Thursdays but first of each month, 8 AM; Amphitheater—Rainbow Babies and Childrens Hospital, Cleveland; sponsor: Department of Pediatrics, Rainbow Babies and Childrens Hospital, cosponsor: Case Western Reserve University School of Medicine; 1 credit hour per conference; contact: Arthur Newman, M.D., Department of Pediatrics, Lakeside Hospital, Cleveland 44106, phone: 216/791-7300.

CLINICAL NEUROSURGICAL SEMINAR: Wednesday,

8 AM; various hospital locations throughout Cleveland; sponsor: Division of Neurosurgery, University Hospitals, Veterans Administration Hospital, Cleveland Metropolitan General Hospital and CWRU School of Medicine; 3 credit hours per session; contact: F. E. Nulsen, M.D., Department of Surgery, Lakeside Hospital, Cleveland 44106, phone: 216/791-7300.

MEDICAL GRAND ROUNDS: Every other Wednesday, 11 AM; Mt. Sinai Hospital Auditorium, Cleveland; sponsor: Department of Medicine, Mt. Sinai Hospital; cosponsor: Case Western Reserve University School of Medicine; 1 credit hour per conference; contact: Dr. Saul Genuth, Department of Medicine, Mt. Sinai Hospital, University Circle, Cleveland 44106, phone: 216/795-6000.

ORTHOPAEDIC CONFERENCE: 2nd, 3rd, 4th, and 5th Saturday, 8 AM; Cafeteria Conference Room A, Mt. Sinai Hospital, Cleveland; sponsor: Division of Orthopaedic Surgery, Mt. Sinai Hospital-CWRU School of Medicine; 2 credit hours per session; contact: Dr. Barry Friedman, Department of Surgery, Mt. Sinai Hospital, Cleveland 44106, phone: 216/795-6000.

SURGERY GRAND ROUNDS: Thursday, 8 AM; House Staff Residence Auditorium, Mt. Sinai Hospital, Cleveland; sponsor: Department of Surgery, Mt. Sinai Hospital-CWRU School of Medicine; 1 credit hour per session; contact: James P. Weaver, M.D., Department of Surgery, Mt. Sinai Hospital, Cleveland 44106, phone: 216/795-6000.

UROLOGY UPDATE: Saturday, 8 AM; Cleveland Clinic and University Hospital, Cleveland-rotates; sponsor: Division of Urology, University Hospitals-CWRU School of Medicine; 2 credit hours per session; contact: Lester Persky, M.D., Department of Surgery, Lakeside Hospital, Cleveland 44106, phone: 216/791-7300, ext. 2530.

Single Course Offerings

January 1977

CLINICAL CORRELATION SEMINAR: January 1 to March 31, 1 day/week; Medical College of Ohio at Toledo; sponsor: Department of Anesthesia, Medical College of Ohio; 2 credit hours/day; contact: J. T. Martin, M.D., P.O. Box 6190, Toledo 43614, phone: 419/381-3556.

INFECTIOUS DISEASE CONFERENCE: January 4, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

CONTINUING MEDICAL EDUCATION CONFERENCES: January 8 and 10; Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour per conference; contact: Ernest Henson, M.D., 1343 N. Fountain Boulevard, Springfield 45501, phone: 513/399-7121, ext. 341.

NUCLEAR MEDICINE: January 10-14; Nuclear Medicine Institute, Hillcrest Hospital, Cleveland; sponsor: Nuclear Medicine Institute; 40 credit hours; fee: \$500 (\$200 resident); contact: D. Bruce Sodee, M.D., Director, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370.

February 1977

TRANSSPHENOIDAL HYPOPHYSECTOMY FOR CANCER OF BREAST AND PROSTATE — Current Status and Medication for Pituitary Surgery: January 11; 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 2 credit hours; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

SURGICAL MANAGEMENT PROBLEMS: January 12-13; Cleveland Clinic Educational Foundation, Cleveland; sponsor: American Medical Association; 12 credit hours; fee: \$150 (\$75 residents); contact: Education Department, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

FAMILY MEDICINE REVIEW: January 15-16, 29-30; Imperial House North, Columbus; sponsor: Ohio Academy of Family Physicians; 12 credit hours/weekend; fee: \$75 member/weekend, \$125 nonmember/weekend, \$25 resident/weekend; contact: Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

PEDIATRIC ECHOCARDIOGRAPHY: January 17-20; Children's Hospital, Cincinnati; sponsor: American College of Cardiology; 23½ credit hours; fee: \$100 members (\$200 nonmembers); contact: American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

THROMBOEMBOLIC DISEASE: January 18, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 2 credit hours; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

COMMON OCULAR PROBLEM FOR FAMILY PHYSICIANS: January 19; Akron City Hospital, Medical/Surgical Classrooms, Akron; sponsor: Akron City Hospital; 4 credit hours; fee: \$7.50; contact: Mrs. Linda Kerlee, Administration Office, 525 E. Market St., Akron 44309, phone: 216/375-3203.

HYPERTENSION: EVALUATION AND THERAPY IN PRIMARY CARE PRACTICE: January 19; Biltmore Towers Hotel, Dayton; sponsor: Greene Memorial Hospital; 6 credit hours; fee: \$25; contact: Arlene Polster, Greene Memorial Hospital, Xenia 44385, phone: 513/429-3200.

ANESTHESIOLOGY (Visiting Professor Program): January 21; Health Education Building, Medical College of Ohio at Toledo; sponsor: Medical College of Ohio; 3 credit hours; contact: John T. Martin, M.D., P.O. Box 6190, Toledo 43614, phone: 419/381-3556.

CME AT RIVERSIDE METHODIST HOSPITAL: January 25, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: January 25, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medi-Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

MEDICAL PROGRESS FOR THE FAMILY PHYSICIAN: January 26-27; Bunts Auditorium, Cleveland Clinic Educational Foundation, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 11¾ credit hours; fee: \$80; contact: Education Department, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

INFECTIOUS DISEASE: February 1, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

INFECTIOUS DISEASE CONFERENCE: February 2; Fawcett Center, 2400 Olentangy River Road, Columbus; sponsor: Ohio State University College of Medicine Center for Continuing Education; 6 credit hours; fee: \$45; contact: OSU College of Medicine, Center for Continuing Education, A-352 Starling Loving Hall, 320 W. 10th Avenue, Columbus 43210, phone: 614/422-4985.

CONTINUING MEDICAL EDUCATION CONFERENCE: February 5 and 19; Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour per conference; contact: Ernest Henson, M.D., 1343 N. Fountain Blvd., Springfield 45501, phone: 513/399-7121, ext. 341.

CARDIOVASCULAR PATIENT CARDIAC REHABILITATION PROGRAMS (Evaluation of): February 8, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: February 8, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

NORMAL AGING-CREATIVE INTERVENTION: February 14-18; Stouffer Dayton Plaza, 5th & Jefferson St., Dayton; sponsor: Postgraduate Medicine, Department of Medicine and Community Medicine of Wright State University School of Medicine; cosponsor: VA, Central State University, and Scripps Foundation of Miami University; 24 credit hours; fee: \$195; contact: John C. Barton, Ph.D., Wright State University, Department PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

PERITONITIS (New Look at): February 15, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 2 credit hours; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

EAR, NOSE AND THROAT PROBLEMS (Practical Management of): February 16; Fawcett Center, 2400 Olentangy River Road, Columbus; sponsor: Ohio State University College of Medicine Center for Continuing Medical Education; 5 credit hours; fee: \$45; contact: OSU College of Medicine, Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210, phone: 614/422-4985.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: February 22, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

NEOPLASIA LYMPHADENOPATHY: February 22, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.



RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

**The Continuing Development
of Health Programs
RESEARCH**

Mailgram 1

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

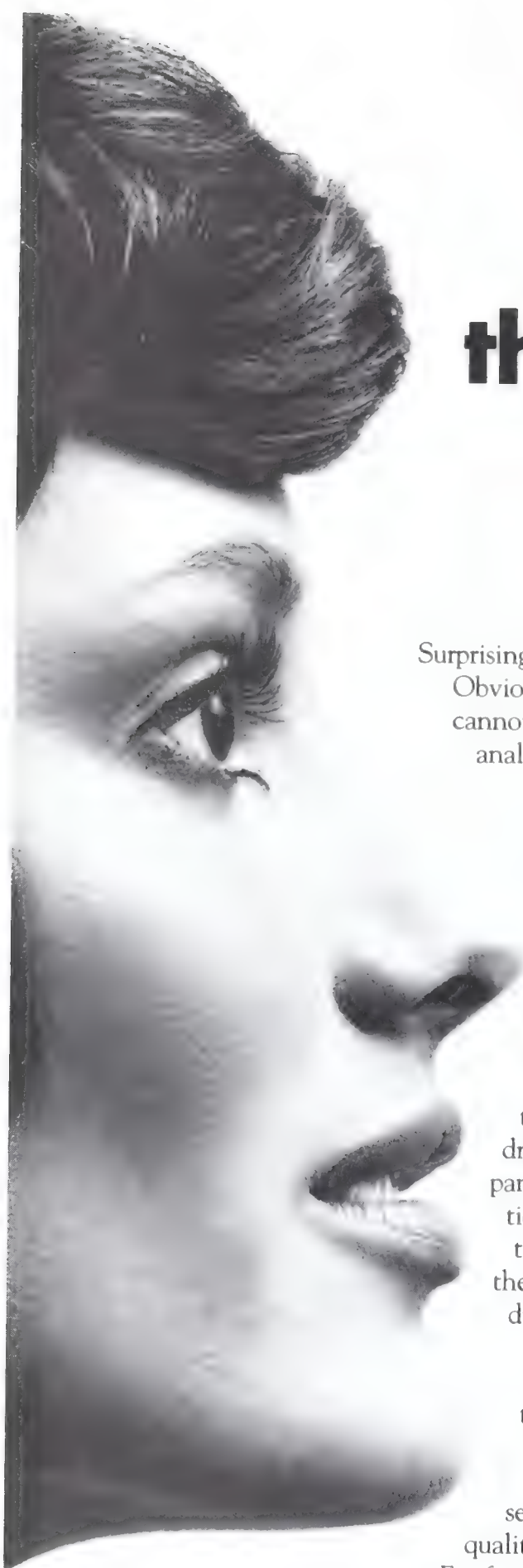
The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



The one the patient takes is never tested.

Surprising, perhaps, but it makes sense when you think about it. Obviously, the actual dose of any prescription drug the patient takes cannot be tested because it would have to be broken down for analysis — after which it could never be used by a patient.

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And, of course, government standards alone do not assure the efficacy and consistency — the quality of each drug you prescribe.

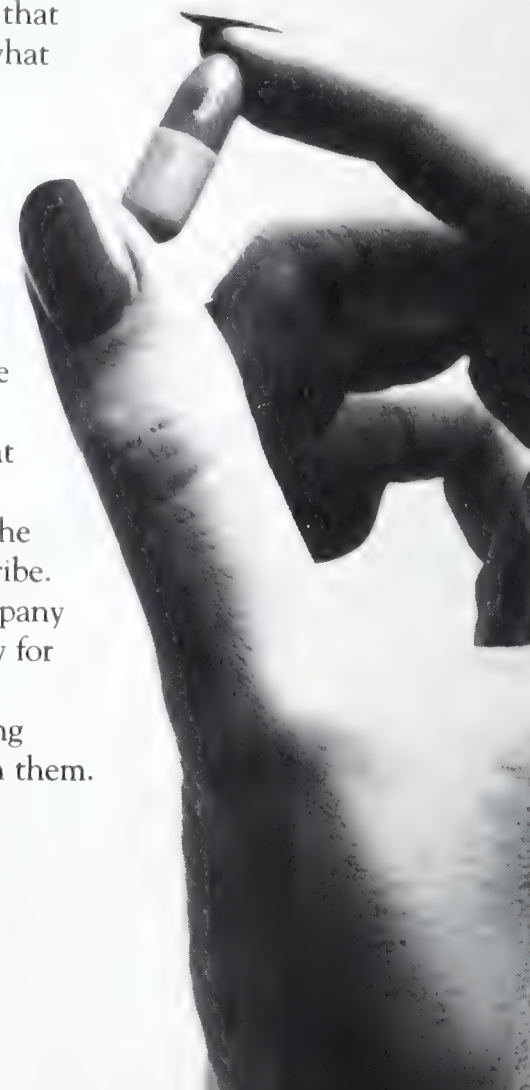
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Burn Care in Central and Southeastern Ohio

A Study of the Role of The Ohio State University Burn Unit

Robert E. Falcone, M.D.
Robert L. Ruberg, M.D.
Ronald B. Berggren, M.D.

A study of The Ohio State University (OSU) Burn Unit was undertaken to assess the role of this unit in burn care for Central and Southeastern Ohio. The unit was found to have a dual function, serving as a critical care facility for surrounding counties and a general burn care facility for Franklin County. A survey of hospitals in Central and Southeastern Ohio showed the majority of hospitals treated lesser burn injuries themselves; but they referred burns of greater than 20 percent of body surface to a specialized burn care facility. In view of these findings, OSU burn teaching programs for medical students, general surgery residents, and plastic surgery residents are being restructured.

IN AN AVERAGE YEAR, 300,000 people in the United States are burned to the extent of requiring hospitalization for burn care. According to Mr. T. Magoto, Chief, Accident Prevention and Product Safety Unit, Ohio Department of Health, an estimated 15,000 to 20,000 people in Ohio are injured from fire each year; records of the Statistical Analysis Unit of that Department indicate that accidents caused by fire and flames were responsible for 272 Ohio deaths in 1974.

The Ohio State University (OSU) Hospitals have maintained a special adult-burn-care facility since 1970. This unit performs teaching, research, and patient-care functions. The following two-part study was undertaken in an effort to reevaluate the role of this facility in the

treatment of burns in Ohio and to reestablish educational goals.

Methods

First, hospital records of 133 burned patients admitted to the OSU Burn Service from January 1, 1972 to December 31, 1975 were reviewed.

The patients were divided into two populations: those from Franklin County (location of the OSU Hospitals) and those from outlying counties. Using Nutt's criteria,¹ these patients were further subdivided into severely and nonseverely burned categories. (A severe burn was defined as any burn involving 20 percent of the body surface; burns associated with major trauma or inhalation injury; all chemical or electrical burns; all burns to the face or full-thickness burns to the hands or feet; all burns in patients 65 years or older; and all burns in patients whose preburn status was judged to be poor.) Referral patterns were determined and the populations compared.

Second, a map of the referral area was constructed (Fig. 1) and questionnaires were mailed to the administrator of each general hospital within the area. These questionnaires were directed at investigating the type of burn treated in the local hospital versus those referred, reasons for referral to OSU, and local interest in Continuing Medical Education Programs for burn care.

Forty-eight questionnaires were sent, and 35 were completed and returned.

Results

There appeared to be significant differences between the Franklin County burn population and those patients from other counties (Table 1). Ninety percent of the 72 "outside" patients had severe burns, while only 67 percent of the 61 patients from Franklin County were classified as severe ($P<0.05$). For those patients severely burned, the total burn surface (TBS) for the Franklin County patients was 24.6 percent, while TBS for non-Franklin County patients was 36.3 percent ($P<0.05$). The average third-degree burn in Franklin County was 16.2 percent and for non-Franklin County was 26.1 percent.

Mortality rates were as follows: 18 percent overall mortality for Franklin County, and 31.9 percent for non-Franklin County. History of preburn illness (hypertension, diabetes, and other diseases) was about equal in both groups.

A map of referral areas was prepared, based on the counties of residence of the patients. Almost all of the patients resided in Central or Southeastern Ohio although several came from other states. Hospitals in the region outlined in Figure 1 were surveyed with questionnaires.

Eleven percent of the hospitals indicated capabilities for managing only burns of less than 10 percent of body surface (Table 2). Another 43 percent treated burns of

TABLE 1. Comparison of Burn Populations

Burn Data	Franklin County %	Non-Franklin County %
Severely burned	67.0	90.0
Avg. TBS severe burn	24.6	36.3
Avg. third-degree burn*	16.2	26.1
History of preburn illness	29.5	32.4
Mortality	18.0	31.9

*In those patients sustaining third-degree burns

TABLE 2. Burns Treated in 35 Hospitals Responding to Survey

Extent of Burns	No. of Hospitals	% of Total Hospitals Responding
10% or less	35/35	100
20% or less	31/35	89
40% or less	16/35	46
More than 40%	4/35	11

20 percent or less body surface. Only 11 percent of the hospitals indicated a capacity for managing burns of greater than 40 percent. Thus, more than one-half of the hospitals surveyed would refer patients with burns of more than 20 percent body surface to a burn center.

Forty-three percent of the hospitals indicated they would refer all cases of significant burns of the hands and feet. Less than one-third of the hospitals treated inhalation injuries or major chemical or electrical burns.

Seventy-four percent of the hospitals in the surveyed area referred patients to the OSU Burn Unit. At the periphery and at individual locations within the surveyed area, several hospitals either additionally or exclusively referred patients to hospitals in Akron, Cincinnati, Cleveland, or Pittsburgh.

The most common reasons given for choosing the OSU Burn Unit for referral were proximity (63 percent),



Ohio Map Showing Area Surveyed and Number of Residents from Each County Treated in OSU Burn Unit, 1972-1975.

- Dr. Falcone, Columbus, Flexible Intern in Surgery, River-side Methodist Hospital.
- Dr. Ruberg, Columbus, Attending Staff, The Ohio State University Hospitals; Provisional Staff, Children's Hos-pital; and Assistant Professor of Surgery, Division of Plastic Surgery, The Ohio State University College of Medicine.
- Dr. Berggren, Columbus, Director, Division of Plastic Sur-gery, The Ohio State University Hospitals and Children's Hospital; and Professor of Surgery, Division of Plastic Surgery, The Ohio State University College of Medicine. Submitted July 1, 1976.

familiarity with the facility (43 percent), and previous experience (37 percent).

Eighty percent of the hospitals indicated an interest in Continuing Medical Education Programs.

Discussion and Conclusions

In part one of our study, figures indicated a difference between the Franklin County burn population and those patients from surrounding counties. The Franklin County patients had fewer severe burns and less total-area burn when compared with the other group. Thus, the OSU Burn Unit appeared to serve a dual role; first, as a *general* burn-care facility for Franklin County residents, and second, as a *critical*-care facility for more severely burned patients from outside counties.

Part two of this study delineated the areas of referral to the OSU Burn Unit. The majority of hospitals in this area apparently refer patients with burns of more than 20 percent body surface to a specialized burn care facility, most commonly OSU. In addition, cases of burns of the hands and feet, inhalation injuries, and chemical or electrical burns were commonly transferred.

Using the foregoing information, a number of guidelines for teaching burn care at The Ohio State University were evolved. First, recognizing that most patients with burns of *under* 20 percent were *kept* in the community hospital, the major focus of teaching medical students should be directed at the physiology and therapy of *minor* burns. Many of the current medical students at OSU have expressed an interest in family practice. In this role, they will encounter minor burn problems frequently. A new teaching program directed at burn care and emphasizing the care of minor burns is being incorporated into the students' surgery course.

Similarly, residents in general surgery should become skilled in the management of burns of up to 20 percent

body surface since the majority of these physicians, when in practice in community hospitals, will be called upon to treat such injuries. Each resident in surgery in the OSU program will now be assigned to a ten-week rotation in plastic surgery, during which time an important responsibility will be working in the OSU Burn Unit.

A residency in plastic surgery at OSU includes extensive experience in the OSU Burn Unit. These physicians must now master the care of patients with major thermal burns as well as inhalation, chemical, and electrical injuries.

In view of the community interest in Continuing Medical Education Programs, an effort is underway to provide such teaching through the OSU Burn Unit. Again, the orientation of such a program, based on the information gained from this study, would be the care of patients with burns of up to approximately 20 percent of body surface.

Summary

A two-part study of the role of The Ohio State University Burn Unit included a review of patient records and a survey of referring hospitals. The unit was found to serve as both a general burn care facility for residents of Franklin County and a critical care facility for residents of surrounding counties. Hospitals in the area of Central and Southeastern Ohio generally referred patients with burns of greater than 20 percent as well as those with associated injuries. In the light of this information, OSU burn teaching programs have been reoriented.

Reference

1. Nutt PC: Burn care standards, *Wis Med J* 73:37-42, 1974.



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Insulin and Proinsulin Metabolism in an Unusual Case of Insulinoma

Kenneth Kreines, M.D.
Jerome I. Starr, M.D.
Mary E. Mako, M.S.

An interesting case of insulinoma is reported in which observations were made of glucose, insulin, and proinsulin levels in the systemic circulation, the portal circulation, and in the tumor. Provocative tests were conducted with glucose, tolbutamide, leucine, and glucagon and the most noteworthy findings included:

1. Abnormally low fasting blood sugar/immunoreactive insulin (FBS/IRI) ratios;
2. Sluggish insulin and excessive hyperglycemic response following oral glucose;
3. Sluggish glucose and insulin responses following oral leucine and intravenous tolbutamide;
4. Brisk glucose and insulin responses following intravenous glucagon;
5. Insulin and proinsulin levels in the portal vein, aorta, and tumor similar to levels reported by others;
6. Elevated absolute fasting serum proinsulin and borderline percent proinsulin; and
7. Inadequate suppression of percent proinsulin following glucose, leucine, and tolbutamide.

DURING THE PAST DECADE, our understanding of the physiology of hypoglycemia was greatly enhanced by the development of precise methods for measuring insulin and proinsulin¹⁻¹⁰ and for defining the responses of glucose and these hormones to a variety of secretagogues such as glucose,^{1,11} tolbutamide,^{12,13} leucine,^{14,15} and glucagon.¹⁶⁻¹⁸ Although these sophisticated techniques have greatly facilitated differential diagnosis, a few cases remain problematic because, unfortunately, no single test has proved to be consistently reliable.^{4-6,9,10,13,15,19-21}

This is the report of a case of insulinoma in which observations were made of insulin and proinsulin levels in the portal and systemic circulations, as well as in the adenoma itself. The case was somewhat unusual in that a brisk insulin response occurred to glucagon but not to glucose, tolbutamide, or leucine.

Methods

The oral glucose tolerance test (100 gm glucose), intravenous tolbutamide test (1.0 gm sodium tolbuta-

mide), intravenous glucagon test (1.0 mg glucagon), and oral leucine tolerance test (200 mg 1-leucine per K) were each performed following an overnight fast. Venous blood was promptly centrifuged and frozen and the serum analyzed in Chicago for immunoreactive insulin (direct IRI) by a modification of the method of Morgan and Lazarow²² and for proinsulin (PI) by a modification of the gel filtration method of Roth et al.²³ Insulin was measured against a human insulin (Ii) standard, while proinsulin was measured against both human proinsulin (PIpi) and human insulin (PIi) standards. The latter was done because of the limited availability of a human proinsulin standard in certain Centers. PIi values usually are about 30 to 40 percent of their corresponding PIpi values. The percent proinsulin ($\%PI = (PIi)/(Ii + PIi)$).

The portal vein and aorta samples were obtained immediately preceding and 30 minutes following resection of the insulinoma, during glucose infusion.

Clinical Data

A 59-year-old salesman complained of a five-year history of insidious loss of memory, judgment, and ability to concentrate, with sporadic attacks of mental confusion and irrational behavior usually associated with fasting.

Results of physical examination and routine laboratory and roentgenologic examinations were normal. The A.M. plasma cortisol level was 19.0 mcg per dl, and the excretions of 17-ketosteroids and 17-hydroxycorticosteroids were 19.7 and 7.3 mg per 24 hours, respectively. Results of provocative tests with glucose, tolbutamide,

(continued on page 707)

Dr. Kreines, Professor of Clinical Medicine, University of Cincinnati College of Medicine, Cincinnati.

Dr. Starr, Associate in Medicine, University of Massachusetts Medical School, Worcester.

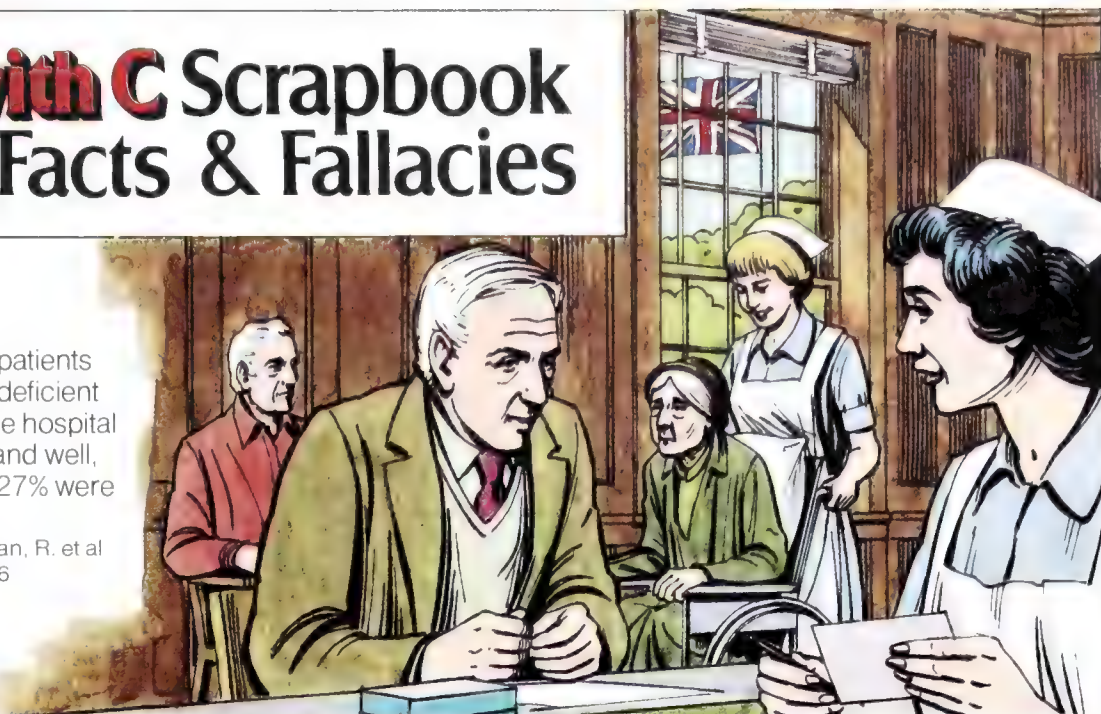
Ms. Mako, Research Associate, Department of Medicine, University of Illinois Medical School, Chicago.

Submitted July 7, 1976.

The **ALLBEE with C** Scrapbook of Vitamin Facts & Fallacies

A study conducted among elderly patients in England showed that 41% were deficient in ascorbic acid on admission to the hospital. Even among those living at home and well, or not sufficiently ill for admission, 27% were deficient in ascorbic acid.

Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al
Diet in Old Age, Brit. Med. J., 1:739, 1966



The loss of riboflavin in milk in a glass container exposed to sunlight for two hours may be as high as 95%.



Quick freezing of vegetables is accompanied by very little ascorbic acid loss. But blanching, washing, and prolonged standing at room temperatures results in considerable reduction in Vitamin C content.

In World War I a unit of 100 beds per division in the Russian army was set aside for scurvy patients. Yet, only 20 cases of scurvy were reported among all American troops in 1917-18.



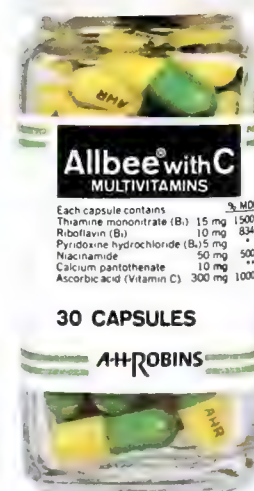
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Phenobarbital (warning: may be habit forming)	($\frac{1}{4}$ gr) 16.2 mg	($\frac{1}{2}$ gr) 32.4 mg
Hyoscyamine sulfate	0.1037 mg	0.1037 mg
Atropine sulfate	0.0194 mg	0.0194 mg
Hyoscine hydrobromide	0.0065 mg	0.0065 mg

Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective: adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

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glucagon, and leucine are shown in Tables 1 and 2 and are discussed herein.

At operation, an 0.8-mm, benign, islet cell adenoma was resected from the head of the pancreas.

Results and Discussion

Plasma FBS/IRI Ratios.— The fasting IRI levels were inappropriately high in relation to those of glucose, a finding highly suggestive of insulinoma, according to several authors,^{9,21,24,25} who stressed the diagnostic importance of an FBS/IRI ratio of less than 2.5. (Each hospital must establish its own ratio because of laboratory variation.) In this particular case, the ratio was less than 2.5 in three of five instances in which it was determined (2.3, 2.4, and 2.3).

IRI and Glucose Responses to Secretagogues.— During the oral glucose tolerance test, hyperglycemia and a sluggish insulin response occurred similar to those reported by Khurana et al in five of 16 reviewed cases of insulinoma.⁶

There was little response of plasma glucose or IRI to tolbutamide, a modest response to leucine, and a brisk response to glucagon, ie, maximum IRI levels were 27.8 μ U/ml following tolbutamide, 50.9 μ U/ml following leucine, and 211.8 μ U/ml following glucagon. One possible explanation for this unusual finding is the availability of fewer tumor receptor sites for glucose, tolbutamide, and leucine than for glucagon. Another possible explanation is the presence of the permissive modulating effect of glucose on insulin secretion during tolbutamide and leucine stimulation when the plasma glucose level was low, but not during glucagon stimula-

tion when the plasma glucose level became elevated.²⁶ In any case, these findings reemphasized the variable insulin response to secretagogues in insulinoma.

IRI and Proinsulin Levels in Portal and Systemic Circulations Before vs After Removal of Tumor.— Immediately before removal of the tumor, the IRI level in the portal vein was 195 μ U/ml, approximately ten times the level in the aorta, which was 20 μ U/ml. Thirty minutes following removal of the tumor, however, the portal vein IRI was only 31 μ U/ml, just five times that of the aorta, which was 6.3 μ U/ml (Table 3). These findings are in keeping with the previous report of Rubenstein et al,⁹ in which the portal-systemic IRI ratio varied from 5 to 22. Blackard and Nelson^{27,28} and Horwitz et al²⁹ have reported portal vein IRI levels of 256 to 650 μ U/ml in normal subjects following glucose administration, levels higher than those observed in our patient, further suggesting that this tumor was relatively insensitive to glucose. It must be emphasized, however, that the present samples were obtained under different conditions than those employed by the other investigators.

In this patient, the portal-systemic proinsulin ratio was 1.8 (11.6/7.3 μ U/ml), close to the ratio of two previously reported cases by Rubenstein et al.⁹ The observation that the percent of proinsulin (%PI) was greater in the aorta than in the portal vein (26 vs 5.6) can be explained by the fact that the IRI level was much higher in the latter. Following removal of the tumor, the IRI and PI levels fell proportionately and the %PI remained essentially unchanged in the portal vein and in the aorta.

Tumor IRI and PI.— The tumor was found to contain 52.5 units of insulin per gram wet weight, of which less

TABLE 1. Oral Glucose Tolerance Before and After Operation

Time (Minutes)	Glucose (mg/dl)	Direct IRI* (μ U/ml)	PIpi* (μ U/ml)	PIi* (μ U/ml)	Ii* (μ U/ml)	% PI
Before Operation						
0	53	16.0	14.6	4.5	12.4	26.6
30	92	32.9	—	—	—	—
60	163	34.9	43.3	10.5	38.2	21.5
120	223	61.0	36.0	8.9	42.5	17.0
180	227	53.5	50.8	12.1	60.6	16.6
240	101	26.6	—	—	—	—
Six Months After Operation						
0	104	6.9	6.9	1.9	7.3	20.2
30	135	45.8	—	—	—	—
60	118	60.5	25.1	6.3	69.3	8.4
120	106	60.3	38.5	9.3	60.9	13.3
180	99	48.6	—	—	—	—

*See text for explanation of abbreviations.

TABLE 2. Tolbutamide, Glucagon, and Leucine Tolerance Before Operation

Time (Minutes)	Glucose (mg/100 ml)	Direct IRI* (μ U/ml)	PIpi* (μ U/ml)	PIi* (μ U/ml)	Ii* (μ U/ml)	% Pi*
1.0 gm Sodium Tolbutamide (Intravenous)						
-30	42	17.9	31.3	7.4	18.5	26.8
0	26	—	—	—	—	—
10	29	24.2	26.6	5.9	23.2	20.4
25	32	27.8	—	—	—	—
40	30	27.5	—	—	—	—
70	17	27.6	—	—	—	—
100	20	—	—	—	—	—
130	20	—	—	—	—	—
180	25	—	—	—	—	—
200 mg/K Leucine (Oral)						
-30	55	24.0	22.9	5.2	19.0	21.6
0	54	20.8	—	—	—	—
30	42	49.0	30.3	7.0	49.6	12.5
60	34	50.9	—	—	—	—
90	32	46.0	—	—	—	—
105	31	42.0	—	—	—	—
1.0 mg Glucagon (Intravenous)						
0	43	17.3	4.4	1.2	13.8	8.0
2	40	60.8	17.6	4.5	62.9	6.7
15	74	211.8	34.9	9.1	229.2	3.8
30	69	127.3	33.7	8.1	142.2	5.9
45	38	39.3	35.7	8.7	38.2	18.6
90	25	25.8	—	—	—	—
120	24	24.2	—	—	—	—

*See text for explanation of abbreviations.

than 10 percent was proinsulin, similar to levels reported by Floyd et al.^{5,30}

Proinsulin Levels and Their Response to Insulin Secretagogues.— In 1971, Gutman et al found reports of seven insulinoma cases with high circulating proinsulin levels and added reports of nine cases of their own.⁷ They noted that the %PI was 28 or greater in three

of seven cases in which it was measured in the fasting state, in six of seven cases following tolbutamide, and never over 20 in controls. Although the fasting IRI levels were normal in three of the 21 insulinoma cases reported by Sherman et al, in one of these cases, the proinsulin level was increased and the %PI was increased in another.⁸ Similarly, Rubenstein et al have

TABLE 3. Insulin and Proinsulin in Portal Vein and Aorta Before and After Removal of Insulinoma

	Portal Vein				Aorta			
	Direct IRI (μ U/ml)	PIi (μ U/ml)	PIpi (μ U/ml)	% Pi	Direct IRI (μ U/ml)	PIi (μ U/ml)	PIpi (μ U/ml)	% PI
Before removal of tumor	195.0	11.6	46.0	5.6	20	7.3	16.0	26
30 minutes after removal of tumor	31.0	4.1	28.0	8.8	6.3	2.5	10.0	28

reported that although the fasting IRI was normal in 11 of 19 cases of insulinoma, PI was normal in only three cases and %PI was normal in only four.⁹ Of the three patients with normal PI levels, one had an elevated fasting IRI and another had an elevated %PI.

In the case presented here, the mean fasting PI level was 4.6 μ U/ml (range: 1.2 to 7.4), exceeding the laboratory normal range of 0.028 to 0.95 μ U/ml, and the mean %PI was 17.9% (range: 6.7 to 26.8) which was borderline in comparison with the laboratory normal of 13.2% (range: 4.6 to 22.8).

Data are still inadequate regarding PI response to stimulation with glucose, tolbutamide, glucagon, and leucine. Several investigators have reported that in normals the %PI declines to less than 8 ng/ml at the time of maximum stimulation because of the disproportionate increase in the IRI.^{7,9,23} In our case, however, the %PI fell from 26.6 to 21.5 following glucose, following leucine from 26.8 to 12.5, and following tolbutamide from 26.8 to 20.4. Following glucagon, the %PI decreased from 8.0 to 3.8 and then rose to 18.6%. Six months after surgery, the patient's fasting and post-glucose PI levels were similar to the preoperative levels.

This investigation was supported in part by grants 5-TO1-AM05165 and AM-13941 from the National Institutes of Health.

References

1. Yalow RS, Berson SA: Immunoassay of plasma insulin in man. *Diabetes* 10:339-344, 1961.
2. Steiner DF, Oyer PE: The biosynthesis of insulin and a probable precursor of insulin by a human islet cell adenoma. *Proc Nat Acad Sci* 57:473-480, 1967.
3. Melani F, Will GR, Rubenstein AH, et al: Proinsulin secretion by a pancreatic beta-cell adenoma. *N Eng J Med* 283:713-719, 1970.
4. Samols E, Marks V: Insulin assay in insulinomas. *Brit Med J* 1:507-510, 1963.
5. Floyd JC Jr, Fajans SS, Knopf RF, et al: Plasma insulin in organic hyperinsulinism: comparative effects of tolbutamide, leucine and glucose. *J Clin Endocrinol Metab* 24:747-760, 1964.
6. Khurana RC, Dhawer VPS, Klayton R, et al: Insulin and glucose patterns in control subjects and in proved insulinoma. *Am J Med Sci* 262:115-128, 1971.
7. Gutman RA, Lazarus NR, Penhos JC, et al: Circulating proinsulin-like material in patients with functioning insulinomas. *N Eng J Med* 284:1003-1008, 1971.
8. Sherman BM, Pek S, Fajans S, et al: Plasma proinsulin in patients with functioning pancreatic islet cell tumors. *J Clin Endocrinol Metab* 35:271-280, 1972.
9. Rubenstein AH, Mako ME, Starr JI, et al: Circulation proinsulin in patients with islet cell tumors. Proc Eighth Inter Diab Fed, Brussels, July 15-20, 1973, *Excerpta Medica, Int Con*, Ser No. 312, 736-752.
10. Alsever RN, Roberts JP, Gerber JG, et al: Insulinoma with low circulating insulin levels: the diagnostic value of proinsulin measurements. *Ann Intern Med* 82:347-350, 1975.
11. Power L: A glucose-responsive insulinoma. *JAMA* 207: 893-896, 1969.
12. Fajans SS, Schneider JM, Schteingart DE, et al: The diagnostic value of sodium tolbutamide in hypoglycemia states. *J Clin Endocrinol Metab* 21:371-386, 1961.
13. Samols E, Marks V: Evaluation of the intravenous tolbutamide test in the recognition and differential diagnosis of spontaneous hypoglycemia, in Tolbutamide . . . After Ten Years, Butterfield WJH, Van Westering W (eds), Lodge Symposium, August, Michigan, March 6-7, 1967, *Excerpta Medica, Int Con*, Ser No. 149, 147-156.
14. Schwartz TB, Flanagan GC, Stuppy GW, et al: The hypoglycemic effect of L-leucine in organic hyperinsulinism. *J Lab Clin Med* 54:944, 1959.
15. Flanagan GC, Schwartz TB, Ryan WG: Studies on patients with islet-cell tumor, including the phenomenon of leucine-induced accentuation of hypoglycemia. *J Clin Endocrinol Metab* 21:401-413, 1961.
16. Marks V: Response to glucagon by subjects with hyperinsulinism from islet-cell tumors. *Brit Med J* 1:1539-1540, 1960.
17. Marks V, Samols E: Glucagon test for insulinoma: a chemical study in 25 cases. *J Clin Pathol* 21:346-352, 1968.
18. Kumar D, Mehtalia SD, Miller LV: Diagnostic use of glucagon-induced insulin response. *Ann Intern Med* 80: 697-701, 1974.
19. Pi-Sunyer FX, Van Itallie TB, Zintel HA: Insulin stimulatory tests in a patient with islet-cell adenoma. *Am J Surg* 118:95-99, 1969.
20. Schein PS, DeLellis RA, Kahn CR, et al: Islet-cell tumors: current concepts and management. *Ann Intern Med* 79:239-257, 1973.
21. Shatney CH, Grage TB: Diagnostic and surgical aspects of insulinoma: a review of twenty-seven cases. *Am J Surg* 127:174-184, 1974.
22. Morgan CR, Lazarow: Immunoassay of insulin: two antibody system. Plasma insulin levels of normal, subdiabetic and diabetic rats. *Diabetes* 12:115-126, 1963.
23. Roth J, Gordon P, Pastan I: "Big Insulin": a new component of plasma insulin detected by immunoassay. *Proc Nat Acad Sci* 61:138-145, 1968.
24. Grunt JA, Pallotta JA, Soeldner JS: Blood sugar, serum insulin and free fatty acid interrelationships during intravenous tolbutamide testing in normal young adults and in patients with insulinoma. *Diabetes* 19:122-126, 1970.
25. Turner RC, Oakley NW, Nabarro JDN: Control of basal insulin secretion, with special reference to the diagnosis of insulinomas. *Brit Med J* 2:132-135, 1971.
26. Cerasi SEE, Luft R: Role of glucose in arginine-induced insulin release in man. *Metabolism* 20:568-579, 1971.
27. Blackard WG, Nelson NC: Portal and peripheral vein immunoreactive insulin concentrations before and after glucose infusion. *Diabetes* 19:302-306, 1970.
28. Blackard WG, Nelson NC: Portal vein insulin concentrations in diabetic subjects. *Diabetes* 20:286-288, 1971.
29. Horwitz DL, Starr JI, Mako ME, et al: Proinsulin, insulin and C-peptide levels in portal and peripheral blood. *Diabetes* 23:350, suppl 1, 1974.
30. Hayashi M, Floyd JC Jr, Fajans SS, et al: Insulin (IRI), proinsulin (PI), glucagon (IRG) and gastrin (IRGa) in pancreatic tumors and plasma of patients with organic hyperinsulinism. *Clin Res* 22:649A, 1974.

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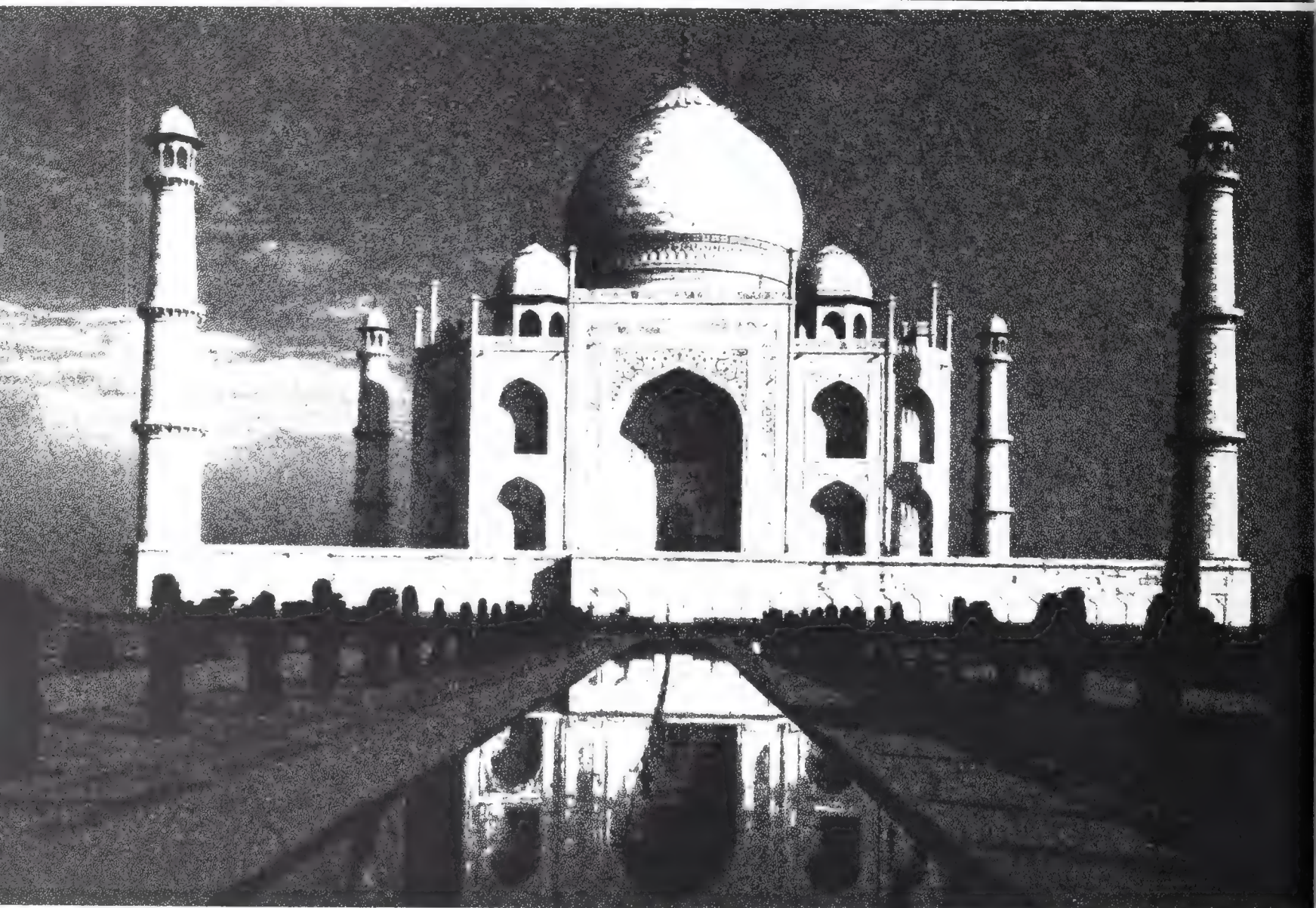
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Maternal Health in Ohio

Maternal Deaths Involving Suicide

By the OSMA Committee on Maternal and Neonatal Health*

IN OUR EXPERIENCE WITH maternal deaths in Ohio, covering a period of 21 years, suicide rarely has been seen as a direct or indirect primary cause of maternal death. Three cases were reported in this column in 1966.¹ The following year, our ten-year survey covering 779 maternal deaths announced and confirmed the relative paucity with which this alarming condition was really related to pregnancy.² That pregnant patients with emotional disturbances (past and present) should be recognized early as high-risk, obstetric patients goes without saying! Herein, the Committee presents a report of three more patients in this category.

The first patient was married, in her third decade of life, and had a family. She had been under psychiatric care for several years (*high-risk* patient). When her pregnancy was confirmed and she seemed insecure about the outcome, she and her husband were advised to consider therapeutic abortion, in consultation with her psychiatrist. They decided against interruption of the gestation. The pregnancy continued an uncomplicated course with the bilateral care of the obstetrician and the psychiatrist. Near term, she became apprehensive, the cervix was "ripe," and labor was induced. Delivery was spontaneous with a living baby; there were no lacerations. On the second postpartum day, the patient requested a

visit from her psychiatrist. He prescribed medication for her depression and advised that she remain in the hospital for several extra days, under medication. Her husband was requested to remain with her during the night, and plans were made to transfer her to a psychiatric facility the next day. However, the next morning, the patient jumped from a window and died in the hospital emergency room shortly thereafter of injuries incurred in the fall.

Cause of Death (Autopsy): Massive body trauma following a suicidal fall; "post partum psychosis" (clinical).

Comment

The Committee studied the facts in this case with deep interest, noting that the patient had a threatening psychiatric history. Members thought she should have been advised not to become pregnant. Information concerning preventive measures is lacking, however, the option to terminate the gestation was deemed to have been offered appropriately. We do not know if the husband was in the patient's room when she jumped from the window. The Committee felt that this maternal death was preventable.

Facts in the second case are quite different and, indeed, somewhat mysterious. This patient was a teenage primigravida who died undelivered in the second trimester of pregnancy. She made one visit to her family physician, who diagnosed her as two months' pregnant and advised her to see her obstetrician for subsequent care. No further word was obtained until three months later, when she had convulsions which were described as "grand mal" and were relieved by treatment with Dilantin® and Compazine.® Her vital signs were normal and the uterus was reported the size of "about five months." Result of an electroencephalogram (EEG) was

*A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal and Neonatal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the studies by the Committee, based on anonymous data submitted, are presented from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

reported as a "stress-triggered, dormant, convulsive disorder." She was hospitalized during another convulsion the next month and discharged several days later on Dilantin® therapy. Several days later, her family reported her missing. More than a week later, her body was found floating in a lake. Newspapers carried reports indicating conflicting stories preceding the misadventure, and quoted police as feeling that the cause of death was suicide. Further details were not available.

Cause of Death (Coroner with Autopsy): Death by drowning. Suicide? (Supplemental report).

Comment

As in similar "mystic" problems, details relating to this case were so inadequate that Committee members felt hampered in a substantial study of the patient's demise. With only "threads of facts" and no further information available, the coroner's diagnosis had to be accepted. It was ascertained from hearsay that the patient had developed anxiety over her pregnant state; that plans for a wedding were "interrupted by epilepsy." The Committee did not rule on the preventability of this death.

The third presentation involved a multigravida in her third decade of life who died undelivered in the third trimester of pregnancy. In one previous pregnancy, she had "psychiatric complications" but no complications of an obstetric nature. She registered with her obstetrician, who noted intermittent depressions which had been temporarily relieved by medication prescribed by a psychiatrist. Her obstetrician noted that the pregnancy seemed to cause her mental state to worsen progressively. Early in the last trimester, she was brought to a hospital emergency room in a stupor, after having taken an overdose of tranquilizers. After she recovered, she was referred to her psychiatrist; details of her management and treatment thereafter were not recorded. Two months later, she was brought to the hospital emergency room, lifeless, with a gunshot wound of the chest; she was pronounced dead. The resident physician promptly performed a cesarean section and delivered a small infant in poor condition.

Cause of Death (Coroner, No Autopsy): Bullet wound of midthorax, exsanguination; suicide.

Comment

The Committee discussed this case for some time, evaluating the meager details provided. Members wondered what measures of protective custody were employed for the patient after her "overdose" and after she returned to her psychiatrist. Furthermore, they questioned her home environment, particularly, where and how she obtained the fatal firearm. On information provided by the patient's obstetrician, he believed the

pregnancy exaggerated the patient's depression. The Committee members felt that the death was pregnancy related and only possibly preventable.

Comment of Consultant

The following comment of a consultant, who is a specialist in obstetrics and gynecology, was given at the request of the Committee:

"Indeed, this consultant proceeds with these remarks harboring some mixed emotions. First, what is our responsibility to the patient, her family, and her unborn child concerning her emotional management over and above direct obstetric care? Actually, we observe her only a *very* short time during intermittent visits. Her social relationships and reactions to her environment compile the huge majority of her life. Obviously then, to denote or discover early variations in her emotions, we must be more alert to evaluate our own observations as well as those from friends, family, and neighbors. Second, after we place a patient in a *high-risk* category, expert management is indicated immediately during both the pregnancy and the puerperium.

"In the first case, I agree with the Committee. True protective care and management seemed to be indicated earlier. In this instance, of course, we have no information concerning previous contraceptive advice.

"The second case poses a real enigma from several angles. Was foul play or poison ruled out? Was the real reason for all the secrecy surrounding this girl's death a social or a legal problem? I wonder if pregnancy was even related to the tragic death.

"The last patient was identified early as a high-risk obstetric patient, and her physician noted that the pregnancy exaggerated her depression progressively. Her unsuccessful (first) attempt at suicide was a signal; the immediate psychiatric management is not recorded. I also wonder 'where she got the gun.'

"Almost all pregnant and puerperal patients undergo *some* depression. They usually have one or more of 'three fears'—a fear for their own safety, a fear for their unborn baby, or a fear of the unknown! The physician must be alert and aggressive in the early recognition and management of tensions and emotional disturbances as they develop in the pregnant woman."

Generic and Trade Names of Drugs

Prochlorperazine— Compazine (Smith Kline & French)
Phenytoin sodium— Dilantin (Parke-Davis)

References

1. OSMA Committee on Maternal Health: Maternal deaths involving suicide. *Ohio State Med J* 62:1294-1295, 1966.
2. OSMA Committee on Maternal Health: Maternal mortality report for Ohio — a 10-year survey, 1955-1964. *Ohio State Med J* 63:323-332, 1967.

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obituaries

CLARE R. ANDERSON, M.D., Akron; University of Nebraska College of Medicine, Omaha, Neb., 1922; age 79; died October 18, member OSMA and AMA.

STANLEY G. ARTER, M.D., Crestline; Ohio State University College of Medicine, 1955; age 46; died October 14; member OSMA and AMA.

TAYLOR W. BARKER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1935; age 67, died September 21; member OSMA and AMA.

SAMUEL W. BELL, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1936; age 66; died October 15; member OSMA and AMA.

ORVILLE B. BURKE, M.D., Dayton; Ohio State University College of Medicine, 1928; age 73; died September 10; member OSMA and AMA.

ANDREW J. DEVANY, M.D., Akron; Northwestern University Medical School, Chicago, 1909; age 94; died October 1.

EDWIN B. EGLI, M.D., Northfield; Yale University School of Medicine, New Haven, Conn., 1928; age 78; died September 30; member OSMA and AMA.

RAY WM. FENTON, M.D., Youngstown; Ohio State University College of Medicine, 1914; age 84; died September 24; member OSMA and AMA.

ROBERT E. GLASGOW, M.D., Kent; Ohio State University College of Medicine, 1945; age 57; died October 5; member OSMA and AMA.

JOSEPH V. HEIMANN, M.D., Cleveland; St. Louis University School of Medicine, 1925; age 79; died September 15; member OSMA and AMA.

NATHAN J. HOBBS, M.D., Toledo; Meharry Medical College of Medicine, Nashville, Tenn., 1924; age 79; died October 3; member OSMA and AMA.

BERNARD KATZ, M.D., Cleveland; University of Louisville School of Medicine, Louisville, Ky., 1928; age 73; died September 27; member OSMA and AMA.

HENRY B. LACEY, M.D., Columbus; Ohio State University College of Medicine, 1932; age 73; died October 11; member OSMA and AMA.

JOHN MILTON OWEN, M.D., Tipp City; Ohio State University College of Medicine, 1931; age 76; died October 8.

GEORGE F. PATTERSON, M.D., Delphos; University of Iowa College of Medicine, Iowa City, Iowa, 1919; age 83; died October 19; member OSMA and AMA.

GILBERT E. SAYLE, M.D., Greenville; University of Cincinnati College of Medicine, 1936; age 68; died October 7; member OSMA and AMA.

STANLEY H. SHENSA, M.D., Cleveland; Ohio State University College of Medicine, 1957; age 44; died September 28; member OSMA and AMA.

EDWARD WAGNER, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1909; age 88; died September 23; member OSMA and AMA.



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(Editor's Note: The following physicians have practiced medicine for 50 or more years. In honor of this achievement, the OSMA has presented to each physician a 50-Year Award plaque and a pin.)

ALLEN (Lima)
Glenn E. Jones

ASHTABULA (Geneva unless noted)
Leslie Eugene Needham
Karlis Nikolajs Pope, Andover

ATHENS
Eugene Omelsky, Cleveland

BELMONT (Barnesville)
Francis Harold Stoup

COLUMBIANA (East Palestine)
Alexander M. Simpson

CUYAHOGA (Cleveland unless noted)
Myron H. August, Florida
Donald H. Baker
William J. Engel, California
Walter Fanelli
James Gray
Harry A. Gusman, Florida
John F. Haas
Samuel Hantman
Grant M. Hawk, Florida
Norman H. Lavine
James T. Ledman
Andrew James Nemecek
Arthur D. Nichol (deceased)
Irvine Heinley Page
Harry Gaskill Peat
John R. Robboy
Solomon S. Sogg
Nicholas M. Steiner, Arizona
Sidney J. Stone
Borivoj Vyroubal
Otto Wellner, California

DEFIANCE (Defiance)
John U. Fauster, Jr.

DELAWARE (Delaware)
Adelbert R. Callander

FRANKLIN (Columbus unless noted)
Oscar L. Coddington, Florida
Herbert Dodd Emswiler, Florida
Francis W. Gosnell
John Lieu
Claude S. Perry
Roy Jacob Secrest
Emmerich von Haam
Charles R. Wilcox

GREENE (Yellow Springs)
Lester W. Sontag

GUERNSEY (Cambridge)
James K. Gibson
Arthur T. Hopwood

HAMILTON (Cincinnati unless noted)
Martin Abraham
John Thomas Burns, California
Charles Elmer Dillard
Samuel Goldblatt, Fairfield
Paul J. Graham
Robert E. Howard
Philip Jaeger
Joseph Charles E. LaVallee
Hans W. Lawrence, Florida
Albert H. Pearlman
Carl W. Pottschmidt
Andrew C. Renz
Stephen L. Vergesslich
Josef Warkany
Abraham M. Wigser

LAKE (Painesville)
Frederick Joseph Dineen

LORAIN (Lorain unless noted)
Albert J. Kirchner
Isadore Leonard Levin, Florida

LUCAS (Toledo unless noted)
Murray E. Goodrich, Michigan
Earl A. Heilner
Arthur Patrick R. James, Maumee
Bernard A. Karwowski
Ernst Moritz Mamlok
James G. Quinlan
Reynold August Tank

MIAMI (Piqua)
William Warner Trostel
Ralph Denman Yates

MONTGOMERY (Dayton unless noted)
James M. Cunningham
Gerald Clark Grout
Lee S. Lenz, Florida
Lloyd Lollar Spitler
Henry L. Strohmeyer
Paul L. Yordy

PIKE (Waverly)
J. Wallace Cleland
Horace Kerr Giffen

RICHLAND (Mansfield)
Clarence Harold Bell
Carl R. Damron

SANDUSKY (Port Clinton unless noted)
Malcolm M. Riddell
Forrest R. Yoke, Bellevue

SCIOTO (Portsmouth)
Thomas Jackson Herbert

STARK (Hartville)
Olin G. Wilson

SUMMIT (Akron unless noted)
Adrian Eugene Davis
Allison F. Errington, Florida
Reginald Franklin Jukes, Florida
Myrl Milton Miller
Noah Miller
John W. Van Sise, Mt. Vernon

TRUMBULL
Zelma M. Mounts

TUSCARAWAS (Sugar Creek unless noted)
Daniel D. Hostetler
Edward Lincoln Miller, Florida

WAYNE (Wooster)
Robert Newton Wright

HEARING

IS

AS PRECIOUS

AS SIGHT HAVE

YOU HAD YOUR HEARING

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COMFORTABLE HEARING

INVESTMENT OF A FEW MINUTES

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

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Beltone
WHEN A HEARING
AID WILL HELP

consider the effect on
coexisting glaucoma when
you prescribe a vasodilator*



a vasodilator that has not been
reported to raise intraocular pressure

VASODILAN[®]

(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

MeadJohnson LABORATORIES

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Bill Regulates Hypodermic Equipment, Drug Samples, and Prescription Blanks

Frank E. Kunkel, Director
State Board of Pharmacy

Amended Substitute House Bill 300, which became effective July 1, 1976, contains three regulatory provisions of immediate interest to Ohio practitioners and their office staffs. The requirements are relatively few and simple, so a few minutes spent getting acquainted with the law—and setting up internal procedures and controls which comply with it—may very well save a good many hours of inconvenience later on dealing with the agencies engaged in enforcement. The requirements concern the following areas.

Hypodermic Equipment

Section 3719.172 of the Revised Code requires distributors of disposable hypodermic syringes and needles to establish a legal purpose for each sale and keep a written record of each transaction.

Practitioners, nurses, or other persons authorized to administer injections in the regular course of their professional employment are authorized to possess disposable hypodermics but are required, after using them, to *render them completely unusable before they are discarded*. A number of inexpensive gadgets are available from most disposable hypodermic suppliers which will quickly damage a syringe and needle beyond all possible further use before it is tossed in the waste. If a practitioner will provide reasonable security and control of his disposable hypodermic equipment and break it before he discards it, he will be complying with the law on this subject.

Drug Samples

The requirements for control of samples of federal legend drugs are similarly few and simple. Section 2925.36 of the Revised Code limits the distribution of physician drug samples to (1) the exchange between the manufacturer or its representative and the practitioner and (2) the exchange between *the practitioner and his patient*.

Such a sample must remain in its original container; be stored under the conditions prescribed by its labeling; bear its expiration date, if applicable; and be stored, distributed, or discarded in such a way that it may not be acquired or used by any unauthorized person. Any physician drug samples found by drug law enforcement agencies outside this system—supplier to practitioner to patient—are considered contraband and are seized and destroyed.

Prescription Blanks

Section 2925.23 of the new law deals with diversion of drugs by use of false or forged prescriptions by prohibiting: (1) the making of a false statement in any prescription, (2) possessing a false or forged prescription, and (3) possessing an uncompleted, preprinted prescription blank or official order form.

Practitioners are urged to provide the same security for their prescription blanks that they usually maintain for their checkbooks. Addicts are competent writers of prescriptions for controlled substances, and careless control of blank prescription pads is a significant source of diversion of drugs from legal channels of distribution into the illicit.

Indepth Look at AMA Programs In December Issue *AM-News*

Your attention is called to the December 13 issue of the *American Medical News* which contains a 16-page insert, "What the AMA Dues Dollar Does." This special report reviews the highlights of 1976 programs and gives a rounded picture of what the member's dollar supported during the year.

As the issue has been sent to all physicians and medical students in the United States, AMA members and nonmembers alike will have the opportunity to judge the worth of the AMA by its programs. All OSMA members are urged to read this report.

An AMA budget for fiscal year 1977 based on expected revenue of \$57,770,000 and expected expenditures of \$46,205,000 was approved by the Board of Trustees. The anticipated favorable balance will enable the AMA to place \$11,565,000 in reserve, a policy reaffirmed by the House of Delegates at the 1975 Annual Convention. Spending will be spread among the six missions of the AMA Plan as follows: Scientific Policy and Information, \$15,547,000; Promote the Effective Delivery of Care, \$3,360,000; Assure and Continue to Improve the Quality of Medical Care, \$8,146,000; Represent the Medical Profession, \$6,265,000; Strengthen Organized Medicine, \$5,524,000; and Internal Support Service, \$5,863,000. Scheduled for the contingency fund is \$1,500,000.

Ban on Medicaid Funding Of Abortions Unconstitutional

The ban on federal Medicaid funding of abortions was declared unconstitutional October 22 by a federal judge in New York City. The ruling, the result of a suit filed by the Planned Parenthood Association and the city's Health and Hospitals Corporation, prevents the

(continued on page 720)

Department of Health Education and Welfare (HEW) from implementing the funding ban in any of the 50 states. HEW announced that it would recommend appeal of the judge's order, but that decision is up to the Justice Department.

The prohibition on the use of federal Medicaid funds for elective abortions was enacted as part of the Labor/HEW appropriations bill for fiscal year 1977. In overturning the ban, Judge John Dooling said that the law would deny needy women the means to exercise their constitutional right to end their pregnancies. The Judge ordered HEW to notify its regional offices that "HEW will provide reimbursement for all abortions provided to Medicaid-eligible women by certified Medicaid providers on the same basis as the Department pays reimbursement for pregnancy and childbirth-related services."

One day earlier in Washington, D.C., Judge John Sirica, acting in a similar suit, refused to overturn the funding ban, although he did not rule on the constitutional issue.

AMA Fee Plaque Available

As the cost of health care becomes a more important national issue with each monthly report of the Consumer

Price Index, physicians find themselves faced with questions about fees. The AMA suggests that one practical way to approach the fee question is to revive use of an AMA plaque entitled "To All My Patients."

The desk or wall piece reads "I invite you to discuss frankly with me any questions regarding my services or fees. The best medical service is based on a friendly, mutual understanding between doctor and patient."

Individual plaques are available from the AMA Order Department for \$2.40 each. For quantities of 100 or more, the price is \$2.19. The order number is OP-33.

Cleveland Hospital Sponsors Program for High School Students

Huron Road Hospital, Cleveland, has initiated a program through which students from 14 area high schools will have an opportunity to explore various fields of medicine. Participants in the program, Student Medical Lecture Series, will come to the hospital and hear Cleveland physicians discuss their specialties and answer questions.

The series of eight lectures, which will run through April 1977, was designed around student interests. Mem-

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

**APATHY • IRRITABILITY
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**Cerebro-
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**A GENTLE CEREBRAL
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Each Cerebro-Nicin capsule contains:
 Pentylentetrazole 100 mg. • Nicotinic Acid 100 mg.
 Ascorbic Acid 100 mg. • Thiamine HCl 25 mg.
 L-Glutamic Acid 50 mg. • Niacinamide 5 mg.
 Riboflavin 2 mg. • Pyridoxine HCl 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold. **CAUTION:** Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
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bers of the lecture committee, Doctors Ernest Friedman, Lucille Nolan, Modesto Peralta, and chairman Lawrence Hadbavny, met with high school representatives to plan the series.

The following lectures are scheduled: Family Practice— Fred T. Suppes, M.D.; Psychiatry— Victor Vic-toroff, M.D.; Cardiovascular Surgery— John Storer, M.D.; Orthopedics— Timothy Stephens, M.D., and B. K. Hoffman, M.D.; Plastic Surgery— Stanley Jaffe, M.D.; Neurosurgery— Herbert Bell, M.D.; and En-docrinology— N. W. Goldston, M.D.

Family Physicians Take Mandatory Recertification Exam

During October, family physicians took the first mandatory recertification examination ever required of American physicians. Mandatory recertification is a revolutionary idea brought to medicine by the American Board of Family Practice. The concept was written into the bylaws of the Board in order to insure that Diplomates of the Board of Family Practice would be in a position to provide the highest quality medical care.

The over 1,400 physicians who sat for the examina-tion represented two groups of candidates: Diplomates in practice who have patient charts and Diplomates who function as family practice teachers or who are in other

nonpractice situations. Those in practice took a half-day, multiple-choice examination with emphasis on new medical developments relating to the family practice specialty. They also reviewed 20 of their own patient charts and answered a set of questions about each prior to the examination. Candidates not in practice and who could not supply charts sat for a two-day certification examination.

Idaho Malpractice Law Upheld

The Idaho Supreme Court has reversed a lower court's decision that the state's malpractice law is un-constitutional. In September 1975, a state district court said that the law's \$150,000 limitation on malpracice awards violated a provision of the state constitution. On October 15, 1976, the Supreme Court said that such a limitation would be constitutional if the legislature had a rational basis for enacting such a law— that is, if the malpractice situation in the state factually justified the limitation. The Supreme Court remanded the case to the district court for an additional hearing on the fac-tual basis for enactment of the law. The case was brought by the Idaho hospital and medical associations along with several physicians and hospitals. The state law, enacted in March 1975, was the first such legisla-tion to include a limit on malpractice awards.

**COLD FEET
LEG CRAMPS
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DISCOMFORT
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LIPO-NICIN

A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500,
1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500,
1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule con-tains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
In a special base of prolonged
therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symp-toms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the thera-peutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require dis-continuation of the drug. Transient headache, itch-ing and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in preg-nant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Write for Literature and Samples



Notice to All OSMA Members

Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA*, will expire on December 31, 1976. Here's how to renew:

Mail your dues now to the SECRETARY-TREASURER OF YOUR COUNTY MEDICAL SOCIETY or to the OSMA if your County Society has asked OSMA to direct bill for all three levels of dues on behalf of the Society.

OSMA dues are \$125. AMA membership dues are \$250. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee-American Medical Political Action Committee (OMPAC-AMPAC) dues are \$35. OMPAC-AMPAC membership is recommended.

Member-in-Training— OSMA membership dues are \$20. Membership entitles physician to all privileges including the right to vote and hold office.

Student Membership— a category of membership for full-time students enrolled in medical schools approved by the AMA. OSMA dues are \$15.

Many members will want to send one check to cover local, state, national, and OMPAC-AMPAC dues. Your local Secretary-Treasurer will forward your state and national dues to the OSMA Columbus Office. That office will certify AMA dues. OMPAC-AMPAC dues will be forwarded to OMPAC Headquarters.

As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal* and copies of the *OSMAgram* and *Your Doctor Reports*, without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA* and the *American Medical News*.

The member who becomes eligible for exemption from dues, because of retirement or disability, should notify the Secretary-Treasurer of his County Medical Society. After exemption has been established, it is automatically renewed annually, unless the status changes.

For further information on medical society membership, contact:
Mrs. Katherine Wisse, OSMA Comptroller, telephone: 614/228-6971.

Famous Fighters



NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin) is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in • infected burns, skin grafts, surgical incisions, otitis externa • primary pyoderma (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to



neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML



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Ohio State Medical Board

Physician Relicensure Program

This article contains important information on the mandatory continuing medical education program which has been approved by the Ohio State Medical Board and certified by the Ohio State Medical Association.

Section 4731.281, Ohio Revised Code, now provides:

Every doctor of medicine licensed to practice medicine or surgery within this state shall, on or before the first day of January 1977, and on or before the first of January every third year thereafter, apply to the State Medical Board for a certificate of triennial registration with the Board upon an application which shall be furnished by the Board, and shall pay at such time a fee of \$50 to the Board.

With the January 1980 and all subsequent applications, the applicant shall include satisfactory evidence to the Board that in the preceding three years the practitioner had completed one hundred fifty hours of continuing medical education certified by the Ohio State Medical Association and approved by the Board. The applicant shall have been given sufficient choice of programs to assume that he has had a reasonable opportunity to participate in continuing medical education programs that are relevant to his medical practice in terms of subject matter and level.

All physicians desiring to register on January 1, 1980, will have to complete the 150-hour requirement as outlined herein. No exceptions exist for those physicians who are currently not working in the medical profession or who are retired.

Outline of Program

The continuing medical education program consists of two categories, Category 1 and Category 2. A description of Categories 1 and 2 is contained in this article. (See "Categories of Acceptable Continuing Medical Education.") At least 60 hours of continuing medical education **must** be earned in Category 1, although the total 150 hours **may** be earned in Category 1. There is a limit of 90 hours for continuing medical education activity falling within Category 2.

The categories of acceptable continuing medical education for licensure are based upon those outlined in the American Medical Association and the Ohio State

Medical Association Physician Recognition Award programs. Category 1 of the mandatory continuing medical education program remains identical to Category 1 of the American Medical Association and the Ohio State Medical Association Physician Recognition Award programs, while Categories 2 through 6 of the American Medical Association and Ohio State Medical Association Physician Recognition Award programs have been combined into one category in the mandatory program, Category 2.

The various limitations on the number of hours allowable in any one of the Categories 2 through 6 of the American Medical Association and Ohio State Medical Association Physician Recognition Award programs have been eliminated from the mandatory program. Thus, one is allowed to accumulate 90 hours toward the 150-hour requirement in any one or more areas under Category 2 (ie, medical teaching).

When undertaking a continuing medical education activity, be certain to ascertain from the sponsor or co-sponsor whether that activity can be credited toward the Category 1 requirement.

Out-of-State Registrants

Those individuals residing out of state must complete the required continuing medical education before license renewal in 1980.

It is important to note that the Medical Board will recognize Category 1 credit attained in any institution accredited for continuing medical education by the American Medical Association or the Ohio State Medical Association, whether that institution is in Ohio or elsewhere.

No provisions exist for reciprocity of continuing medical education requirements for re-registration between Ohio and other states. Information on continuing medical education activity must be submitted as outlined in the section "Evidence of Completion" contained in this article.

Internships, Residencies, And Fellowships

Fifty hours of Category 1 credit may be claimed for each full year of internship, residency, or fellowship training taken in a program that has been approved by the Liaison Committee on Graduate Medical Education. Study for a medically related degree, such as a masters degree in public health, may also be included. Full-time study for part of a year is accepted as one credit hour per week. Credits may not be claimed in any other category during the time in which the physician was in full-time training in an approved program. Credit may be claimed in Category 2 for nonapproved internship, residency, or fellowship training taken outside the United States. Training outside the United States as part of a Liaison Committee on Graduate Medical Education-approved program should be claimed in Category 1 and the approved program identified. **The training must have been taken during the period January 1, 1977 to December 31, 1979.**

Continuing Medical Education Requirements for Individuals Licensed During Triennium

Those people receiving Ohio licenses in the interim period between triennial registrations need not complete the full 50-hour requirement. Instead, the following schedule indicates the number of hours they will be required to accumulate before the January 1980 registration.

Individuals licensed between January 1, 1977 and December 31, 1977 must complete a total of 100 hours of continuing medical education. At least 40 hours of continuing medical education **must** be earned in Category 1, although the total 100 hours **may** be earned in Category 1. There is a **limit** of 60 hours for continuing medical education activity falling within Category 2.

Individuals licensed between January 1, 1978 and

December 31, 1978 must complete a total of 50 hours of continuing medical education. At least 20 hours of continuing medical education **must** be earned in Category 1, although the total 50 hours **may** be earned in Category 1. There is a **limit** of 30 hours for continuing medical education activity falling within Category 2.

Individuals licensed between January 1, 1979 and April 30, 1979 must complete a total of 25 hours of continuing medical education. At least ten hours of continuing medical education **must** be earned in Category 1, although the total 25 hours **may** be earned in Category 1. There is a **limit** of 15 hours for continuing medical education activities falling within Category 2.

Individuals licensed between May 1, 1979 and December 31, 1979 **WILL NOT** be required to complete any continuing medical education requirements before the January 1980 registration.

Table 1 is included as an outline of these requirements for individuals receiving their Ohio licenses in the interim period between triennial registrations.

Evidence of Completion

The renewal application (data processing card) for the January 1980 registration will contain a statement *similar* to the following which must be signed by the applying physician:

I certify, under the penalty of the loss of my right to practice medicine and surgery in the State of Ohio, that I have during the last triennium completed the requisite hours of continuing medical education certified by the Ohio State Medical Association or the Ohio Osteopathic Association and approved by the State Medical Board as prescribed herein, and have an accurate log indicating the dates, location, description of learning activity, sponsor, hours of study, and category which has been submitted to the Ohio State Medical Board.

- a. One hundred and fifty hours for those licensed before January 1, 1977.
- b. One hundred hours for those licensed between January 1, 1977 and December 31, 1977.
- c. Fifty hours for those licensed between January 1, 1978 and December 31, 1978.

(continued on page 726)

TABLE 1. Requirements for Individuals Receiving Their Ohio License Interim Period Between Triennial Registrations

Period Within Which License Initially Received	Total Credits Required (Hrs.)	Minimum Category 1	Maximum Category 2
Jan. 1, 1977—Dec. 31, 1977	100	40	60
Jan. 1, 1978—Dec. 31, 1978	50	20	30
Jan. 1, 1979—Apr. 30, 1979	25	10	15
May 1, 1979—Dec. 31, 1979	0	0	0

State Medical Board Relicensure Program *(continued)*

d. Twenty-five hours for those licensed between January 1, 1979 and April 30, 1979.

e. Zero hours for those licensed between May 1, 1979 and December 31, 1979.

Signature

At the end of this article is a "Log of Continuing Medical Education" which must be completed and submitted to the State Medical Board before the January 1980 renewal.

You should submit your continuing medical education log to the Ohio State Medical Board immediately upon completion of the required hours of continuing medical education.

Mail your completed "Log of Continuing Medical Education Activities" to the Ohio State Medical Board, Continuing Medical Education Log, 180 East Broad Street, Suite 1006, Columbus, Ohio 43215.

In lieu of completing the enclosed "Log of Continuing Medical Education Activities," the registering physician may (as an alternative, submit a photocopy of one of the following:

1. An entire, completed "Application for the American Medical Association Physician Recognition Award for Participation in Continuing Medical Education" which discloses completion of the required hours of continuing medical education within the period January 1, 1977 to December 31, 1979. The application **must** list the actual continuing medical education activities undertaken and not simply show that a physician has met the requirements of other organizations.
2. An entire completed "Application for the Ohio State Medical Association Physician Recognition Award for Participation in Continuing Medical Education" which discloses completion of the required hours of continuing medical education within the period of January 1, 1977 to December 31, 1979. The application **must** list the actual continuing medical education activities undertaken and not simply show that a physician has met the requirements of other organizations.
3. A computer listing from the American Academy of Family Physicians showing that a physician has met the American Academy of Family Physicians Continuing Education Requirements within the period January 1, 1977 to December 31, 1979.
4. A transcript from the American College of Obstetricians and Gynecologists showing completion of the continuing professional development program within the period January 1, 1977 to December 31, 1979.

Submit the appropriate copy to the Ohio State Medical Board, Continuing Medical Education Log, 180 East Broad Street, Suite 1006, Columbus, Ohio 43215.

Activities Not Acceptable for Credit Toward the Continuing Medical Education Requirement

No credit for continuing medical education can be given for service on councils, committees, task forces, etc. of medical societies, hospitals, or other medical organizations or institutions. For example, credit should not be claimed for service as president of a medical society, nor should credit be claimed for the education which is incidental to the regular professional activities of a physician, such as learning what may occur from clinical experiences or conducting research.

Serving on a board of medical examiners, or as a member of a community organization planning for health services and facilities, cannot be accepted toward the continuing medical education requirement. If, however, a physician took a short course to improve his or her ability to serve on a medical licensure board or on the board of a community health planning agency, this continuing medical education would be creditable in Category 1 or 2, whichever is appropriate.

It is important that a physician keep accurate and complete information, including any available documents concerning continuing medical education activities during the period January 1, 1977 to December 31, 1979, to avoid any question of completion of the hours of continuing medical education necessary before the January 1980 registration. This information should be kept available to agents of the State Medical Board for review.

Categories of Acceptable Continuing Medical Education

Category 1:

CME Activities With Accredited Sponsorship

At least 60 credits **must** be earned in this category. The total 150 credits **may** be earned in this category.

Criteria:

Category 1 activities are those planned CME programs sponsored by an organization or institution accredited by the American Medical Association's Council on Medical Education or the Ohio State Medical Association's Commission on Medical Education.

Credit may be claimed in Category 1 for planned programs of CME that are cosponsored by an AMA or OSMA accredited organization/institution, *provided*

TABLE 2. Audiovisual Materials

A. Where audiovisual materials are used by groups of physicians or by an individual physician as **part of a course** (including a correspondence course) that meets the definition of a planned program of CME and has accredited sponsorship or cosponsorship, the time spent in the use of the audiovisual materials should be included as a part of the course in Category 1.

B. Where audiovisual materials are used by physician groups, **and this is the only educational method used**, Category 1 credit may be claimed if the materials are sponsored or cosponsored by an accredited sponsor, the program complies with the definition of a planned program of CME and there is an instructor present to supplement the program in terms of local CME needs and the educational objectives of the group.

C. Where only audiovisual materials are used by a physician on an **individual basis**, Category 1 credit may be claimed if all of the following are met:

- (1) Audiovisual program or materials are sponsored by an accredited organization and comply with the definition of a planned program of CME.
- (2) Audiovisual program contains supplemental materials, such as syllabi, study guides, references or tests; is evaluated by the sponsoring organization; and the sponsoring organization has a method of documenting physician participation.

Requirement #2 could be fulfilled by a knowledge-recall examination which is returned to the sponsor for scoring and as evidence of participation.

For individual physician use of audiovisual materials for CME as described above, there is a 45-credit-hour limitation in Category 1. An additional 22 credit hours may be claimed as self-instruction in Category 2, if they are earned.

that each cosponsor is actively involved in the planning, implementation, and evaluation of the program and accepts responsibility for its quality.

A current list of accredited sponsors of CME is maintained by the State Medical Board and the OSMA Commission on Education.

The types of CME activity that *can be developed* as planned programs include: grand rounds/teaching rounds; departmental scientific meetings; seminars; workshops; clinical traineeships/mini-residencies; scientific sessions of medical and medical specialties societies, including local, regional, state, national, or international meetings; visiting lecturer/professor programs; CME courses; and audiovisual materials. (See Table 2 for details.)

Value:

One credit for each hour of participation.

Category 2:

This category includes CME activities with non-accredited sponsorship; medical teaching; papers, publications, books, presentations and exhibits; nonsupervised, individual CME activities; and other meritorious learning experiences.

There is a limit of 90 credits for this category. The 90 credits in Category 2 may be achieved in any one or more of the following areas:

CME Activities With Nonaccredited Sponsorship

Criteria:

Credit in this category may be claimed for CME activities sponsored by a medical organization/institution that is **not accredited** for CME.

Scientific medical meetings and CME programs not within the definition of Category 1 are creditable in Category 2.

Credit may also be claimed in this category for CME programs sponsored by nonaccredited organizations outside the United States.

Value:

One credit for each hour of participation.

Medical Teaching

Criteria:

Student-contact teaching of medical students, interns, residents, practicing physicians, and allied health professionals.

Serving as a personal preceptor to a preceptee who is a medical student, intern, or resident.

Value:

One credit for each hour of teaching; one credit for each hour as a preceptor.

(continued on page 728)

State Medical Board Relicensure Program *(continued)*

Papers, Publications, Books, Presentations, and Exhibits

Criteria:

Credit may be claimed for a paper or publication or for each chapter of a book that is authored and published. A paper must be published in a recognized medical journal.

A presentation or an exhibit must be offered to a professional audience, which can include allied health professionals.

Credit may be claimed only for the first time the materials are presented and should be claimed as of the date materials were presented or published.

Value:

Ten credits for each presentation or publication.

Nonsupervised Individual CME Activities

Criteria:

CME activities that are not personally supervised.

A. Self-Instruction

- (1) Individual, nonsupervised use of audiovisual materials, ie, audiotapes, videotapes, films, tape-slide sets, slides, etc.
- (2) Individual participation in radio, television, or telephone networks, without local supervision.
- (3) Programmed medical education materials, including individual, nonsupervised use of teaching devices, ie, computer-assisted instruction.
- (4) Individual reading of medical publications.

Value:

One credit for each hour of participation.

B. Consultation

- (1) Number of hours of participation, name of consultant, and topic discussed should be stated.
- (2) Consultant may receive credit in Category 3 (Medical Teaching).

Value:

One credit for each hour of consultation time.

C. Patient Care Review

Peer review activities, ie, medical audit, consecutive case conferences, utilization review, participation in a Professional Standards Review Organization (PSRO).

Value:

One credit for each hour of participation.

D. Self-Assessment Programs

Value:

One credit for each hour of participation.

E. Specialty Board Preparation

Nonsupervised, individual CME activities in preparation for certification or recertification by a specialty board.

Value:

One credit for each hour of participation.

Other Meritorious Learning Experiences

Criteria:

- A. Preferably, a medical educator should be involved in the planning, implementation, and evaluation of the activity.
- B. Provide answers to the following questions:
 - (1) What medical education need was the experience designed to meet?
 - (2) How was the educational need determined?
 - (3) What was the educational plan?
 - (4) What educational methods were used?
 - (5) Who were the instructors? Their qualifications.
 - (6) How was the educational experience evaluated in terms of improvement of patient care?

Value:

Value is dependent on responses to questions B(1-6).

Maximum credit equals one credit for each hour of participation.

This section, "Ohio State Medical Board, Physician Relicensure Program," may be duplicated.

The "Log of Continuing Medical Education Activities," appearing on pages 729 and 730 of this issue, is printed for the use of the physician. He should clip and complete the form as he meets the Continuing Medical Education requirements.

Log of Continuing Medical Education Activities for the Period January 1, 1977 to December 31, 1979

CATEGORY 1: CME Activities with Accredited Sponsorship

At least 60 credits *must* be earned in this category
The total 150 credits *may* be earned in this category

I CERTIFY THE FOLLOWING TO BE TRUE AND CORRECT
FOR THE PERIOD JANUARY 1, 1977 to DECEMBER 31,
1979. This form must be completed, signed and
returned for proper credit.

(MUST BE PRINTED OR TYPED)

Signature: _____

[illegible]

CATEGORY 2: CME Activities with Non-accredited Sponsorship; Medical Teaching; Papers, Publications, Books and Exhibits; Non-Supervised Individual CME Activities; and Other Meritorious Learning Experiences.

There is a *limit of 90 credits* for this category

(MUST BE PRINTED OR TYPED)

When Completed Return to:
Ohio State Medical Board
Continuing Medical Education
180 East Broad Street
Suite 1006
Columbus, Ohio 43215

[illegible]

COLLEAGUES IN THE NEWS . . .

Physicians Appointed to State Health Coordinating Council

John H. Ackerman, M.D., Director of the Ohio Department of Health, has announced the appointment of 63 people to the newly established Statewide Health Coordinating Council (SHCC). Upon designation of a Health Service Agency for southeast Ohio, four additional appointments will be made to represent that area.

Formation of SHCC was mandated by the Health Planning and Resources Development Act of 1974. The new council replaced the Comprehensive Health Planning Advisory Council and will be responsible for preparation of a state health plan and review of budgets and applications for assistance of the Health Service Agencies.

The council will also advise the State Health Planning and Development Agency in the performance of its functions and will review every state plan or application submitted for funding to the United States Department of Health, Education, and Welfare.

While appointees represent most major health professions, more than half are health care consumers. Physicians appointed to the SHCC and the areas they represent are as follows:

DONN F. COVERT, M.D.— Mahoning Valley Health Planning Association;

HENRY G. CRAMBLETT, M.D.— Mid-Ohio Health Planning Federation;

ALFORD C. DILLER, M.D.— West Central Ohio Health Systems Agency;

WILLIAM C. EARL, M.D.— Mid-Ohio Health Planning Federation;

STEPHEN P. HOGG, M.D.— Health Planning Association of Central Ohio River Valley;

C. WILLIAM KECK, M.D., M.P.H.— Health Systems Agency of Summit-Portage County;

TIMOTHY B. MORITZ, M.D.— Ohio Department of Mental Health and Mental Retardation;

ROBERT N. SMITH, M.D.— Ohio State Medical Association; and

FREDERICK SUPPES, M.D.— Metropolitan Health Planning Corporation.

MICHAEL ALEXANDER, M.D., Columbus, has been named Medical Director of the Franklin County Society for Crippled Children. Dr. Alexander is also Assistant Professor of Pediatrics and Physical Medicine at The Ohio State University College of Medicine.

RAFAEL BENDEZU, M.D., Cleveland, has been appointed to the staff of the Ambulatory Health Care Department and Department of Medicine of Saint Luke's Hospital. Dr. Bendezu will be involved with teaching as well as patient care in the endocrinology service.

EDGAR S. BOWERFIND, M.D., Cleveland, has been elected President of the Physicians Peer Review Organization of his area. Dr. Bowerfind is on the staff of University Hospitals.

CHARLES L. CASSADY, M.D., Cleveland has been elected program chairman of the Northeastern Ohio Otolaryngology Club. He is also serving a three-year term as Director, District IV, Cleveland Academy of Medicine, and served as a Delegate for the Fifth District at the 1976 Ohio State Medical Association Annual Meeting.

ROBERT M. CURRAN, M.D., Mentor, has been appointed to the Lake County Center on Alcoholism Board. The center was founded by concerned local citizens and is chartered by the state to promote public understanding and support for alcoholics and drug addicts.

RICHARD H. FOSS, M.D., of the Division of Ophthalmology at Saint Luke's Hospital, Cleveland, has been appointed Chief of Ophthalmology at Marymount Hospital.

SAUL GENUTH, M.D., and **VICTOR VERTES, M.D.**, Cleveland, received the Brandeis University Distinguished Community Service Awards. Dr. Genuth is Director of the Shirley and Maurice Saltzman Institute for Clinical Investigation at the Mt. Sinai Hospital of Cleveland. Dr. Vertes directs Mt. Sinai's Department of Medicine.

JACK L. HARRIS, M.D., Middletown, has been elected President of the American Cancer Society, Ohio Division, Inc. A member of the Board of Trustees of the Society, Dr. Harris is medical director of the Middletown Works of Armco Steel Corporation. He also serves as Assistant Clinical Professor of Occupational Medicine at the University of Cincinnati College of Medicine and President of the Southwestern Ohio Regional Council on Alcoholism. Additionally, Dr. Harris is a member of the American Association of Occupational Medicine and the Industrial Health Committee of the American Iron and Steel Institute and is chairman of the Middletown Hospital disaster committee.

WILLIAM HERMAN, M.D., and **EARL E. SMITH, M.D.**, Cleveland, have received distinguished service awards from the Northern Ohio Pediatric Society.

ARTHUR J. HORESH, M.D., Cleveland, was elected to the Board of Trustees of the National Asthma-
(continued on page 734)

Crossing County Lines

Scholarships Awarded by Lorain County Medical Foundation

The September meeting of the Lorain County Medical Society featured presentation of scholarships by the Board of Supervisors of the Lorain County Medical Foundation to three medical, seven nursing, one medical laboratory technology, and one speech pathology student(s). During the summer, 87 applications were reviewed by the Foundation Board members; and the finalists were selected on the recommendation of a screening committee chaired by John B. McCoy, M.D.

Otto B. Schoepfle, Chairman of the Board of Supervisors of the Medical Foundation, presented the scholarships, which varied in the amount of the award depending on the field of study. The medical students who received scholarships are Cathy A. Krosky, Lorain, Medical College of Ohio at Toledo; Richard J. Kovacs, Elyria, University of Cincinnati College of Medicine; and William J. Kovacs, Elyria, University of Chicago Pritzker School of Medicine.

These scholarships bring the total amount awarded by the Medical Foundation since it was established in 1963 to \$36,025. The scholarship fund was developed at that time with surplus funds from the 1962-1963 Sabin Oral Polio Vaccine Program cosponsored throughout Lorain County by the Medical Society and area health departments. The Lorain County Medical Society Auxiliary has been a prime benefactor of the Foundation's scholarship program with total contributions since 1968 amounting to approximately \$21,000.

Consortium Formed in S.W. Ohio

Four southwestern county medical societies have formed a consortium to exhibit the profession's intention to play a major role in comprehensive health planning in their area.

The Cincinnati Central Ohio River Valley Health Systems Agency (CORV-HSA) has divided the 11 counties in its service area into four subareas. The Eastern Subarea includes the rural counties of Adams, Brown, Clermont, and Highland.

A consortium of hospitals and consumers (patients) in these counties had previously been formed to participate in the subarea CORV-HSA planning. Significantly, the consumers are a direct arm of CORV-HSA and have become a nonprofit corporation for the purpose of developing a network of six to eight primary health clinics with central administration to recruit physicians for them.

The medical society consortium will provide parallel participation in health planning for the subarea. The Board of Trustees for the consortium consists of presidents of the societies plus one at-large physician nominated to serve as the spokesman.

1976-1977 Officers Inducted At Cincinnati Annual Meeting

The Cincinnati Academy of Medicine held its Annual Meeting during September at which time Stanley J. Lucas, M.D., was installed as President of the Academy. Other officers for the 1976-1977 term are Carl G. Thompson, M.D., president-elect; John H. Wulsin, M.D., secretary; George C. Hale, Sr., M.D., treasurer; trustees John E. Albers, M.D., Richard B. Budde, M.D., and Donald I. Radin, M.D.; and councilmen-at-large Stewart B. Dunsker, M.D., Rae E. Hartman, M.D., and Donald E. Brinkman, M.D. Immediate past president is Neal N. Early, M.D.

Greeting Cincinnati physicians were the evening's guests, Cincinnati Mayor Bobbie Sterne and University of Cincinnati College of Medicine Dean Robert S. Daniels, M.D.

In his inaugural address, Dr. Lucas outlined the major areas of challenge to medicine: medicine's relationship to third-party payers, especially government agencies; the professional liability crisis; increasing med-

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ical care costs; and a need for increased numbers of physicians in the area of primary care.

Concerning national health insurance, Dr. Lucas felt those with lengthy illnesses or low incomes should be helped by adequate government programs. "But," he said, "a comprehensive, mandatory program is totally unnecessary and would be counterproductive. It would be costly, inefficient, and impersonal." He cautioned that whatever the final form of financial help, it should not interfere with the personal, one-to-one type physician/patient relationship and a person's private choice of physician.

"A throw-away, consumer-oriented, litigious society demanding instant success, instant happiness, and instant reward is the basic issue in the medical professional liability crisis," stated Dr. Lucas. Medicine's tremendous advances in the past decade have probably contributed to patients' expectations of perfection and "despite arguments by sensation-seeking individuals, ineptness of physicians is probably the smallest factor in the malpractice scenario." Dr. Lucas believes that physicians should work toward tighter control of court procedures, binding arbitration, a reduction in exorbitant attorney contingency fees, counterclaims for frivolous and nonmeritorious suits, and more accountability from insurance companies.

Have You Seen This Publication?



Do your patients know what to do about depression during the holidays? Are they aware of the dangers associated with the new movement toward having babies at home? Do they know that the average physician spends more time in continuing education than any other professional group? They will learn about all this and more just by reading the December issue of the OSMA patient publication, *Your Doctor Reports*. Make sure it reaches your waiting room.

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COLLEAGUES IN THE NEWS . . .

(continued from page 731)

matic Children's Foundation. Dr. Horesh is the former Director of the Pediatric Allergy Clinic at University Hospitals.

MICHAEL I. JACOBSON, M.D., Youngstown, has been named full-time Director of Physical Medicine and Rehabilitation at St. Elizabeth Medical Center. Dr. Jacobson, who was formerly Associate Director of Rehabilitative Medicine at St. Barnabas Hospital in New York, is certified by the American Board of Physical Medicine and Rehabilitation. His major responsibility at St. Elizabeth will be the development and clinical direction of the Department of Physical Medicine and Rehabilitation, which includes physical and occupational therapy.

JEROME KLEINERMAN, M.D., Cleveland, is Vice-President of the Northeast Ohio Affiliate of the American Heart Association for the 1976-1977 term. Dr. Kleinerman serves as Director of the Department of Pathology of Saint Luke's Hospital.

JAMES J. LaPOLLA, M.D., has been named Acting Medical Director at Apple Creek State Institute. Dr. LaPolla, a Warren pediatrician, has served as state chairman for the Ohio Special Olympics for the Retarded, chairman of the Trumbull County Board of Mental Retardation, and secretary of the Trumbull County Board of Mental Health and Mental Retardation.

WILLIAM J. McCARTHY, M.D., has retired as Director of Emergency Physicians at Ashtabula General Hospital. Dr. McCarthy ended a practice that spanned 45 years with a party that was attended by most of his ten children.

MIKE MESHINPOOSH, M.D., Conneaut, has been appointed chairman of the county program committee of the American Heart Association, Northeast Ohio Affiliate for Ashtabula County. The committee is responsible for planning and implementing the Association's community programs in Ashtabula County.

JOHN W. MOSES, M.D., is the new Associate Director of Medical Affairs at Akron City Hospital. He succeeds **E. A. RIEMENSCHNEIDER, M.D.**, who is retiring. Dr. Moses has served as Medical Education Director at Mount Carmel Mercy Hospital and Medical Center in Detroit.

JOHN O'BELL, M.D., Cleveland, has been named acting director of neonatology at Fairview General Hospital. Dr. O'Bell is a graduate of Case Western Reserve University School of Medicine and served his residency at Rainbow Babies and Childrens Hospital. He also was a neonatology fellow at Duke University, Durham, North Carolina.

CHARLES G. POPELKA, M.D., Cleveland, has been appointed Director of the Division of Pulmonary Diseases at Saint Luke's Hospital. A graduate of the University of Cincinnati School of Medicine, Dr. Popelka took his general medical training at Akron General Hospital and at Mercy Hospital in Pittsburgh. For the past two years, he has been a Fellow in Pulmonary Disease at Case Western Reserve University School of Medicine.

WILLIAM V. SHARP, M.D., Silver Lake, received a grant from the national research committee of the American Heart Association. Dr. Sharp is Director of the Vascular Research Laboratory at Akron City Hospital.

Special recognition for 25 years of service to Marymount Hospital, Garfield Heights, was awarded to several area physicians. Four of the physicians were honored for the outstanding and dedicated service they performed for Marymount from 1951 to 1976. They were **MILDRED H. SHELLY, M.D.**, a psychiatrist and medical director of the Marymount Hospital Mental Health Center; **FRANKLIN J. SIMECEK, M.D.**, a surgeon; **DONALD A. SNYDER, M.D.**, a surgeon; and **CARL E. ZEITHAML, M.D.**, a pediatrician and head of the Department of Pediatrics since 1952.

Other plaques for meritorious service to Marymount during the 25-year span were given to **RALPH I. FRIED, M.D.**; **ROBERT KURZBAUER, M.D.**; **ERNEST J. McCAMPBELL, M.D.**; **MILDRED MATOUSEK, M.D.**; and **JOSEPH E. WOLFE, M.D.**

NICHOLAS G. DePIERO, M.D., was presented a plaque in recognition of his service as president of the hospital medical staff. He has directed the Anesthesiology Department at Marymount Hospital since 1950 and also has headed the Department of Medical Education since 1962.

GEORGE E. SPENCER, M.D., Cleveland, has been elected to numerous committees including the nominating committees of the American Academy of Orthopaedic Surgeons and the Cleveland Orthopaedic Club; chairman of the admissions committee of the American Academy of Orthopaedic Surgeons; American Orthopaedic Association Guest Resident Program; and Ohio Orthopaedic Society meeting local arrangements chairman. Dr. Spencer is Director of the Division of Orthopaedic Surgery at Saint Luke's Hospital.

THOMAS D. STEVENSON, M.D., Delaware, is the newly elected Vice-President of the American Cancer

Society, Ohio Division, Inc. Dr. Stevenson, who was instrumental in starting the Visiting Tumor Boards Program and the Clinical Oncology Community Coordination at The Ohio State University, is Director of the Hematology/Oncology Division at Riverside Methodist Hospital, Columbus.

CHARLES TRAMONT, M.D., a family physician in Mt. Vernon for the past 38 years, retired to Florida in October. Dr. Tramont, a pioneer in radio broadcasting, was one of the founders of Knox County's radio station, WMVO, and had served as President of the WMVO Board.

G. E. VORHIES, M.D., was honored by Scio residents upon his retirement from active practice. Dr. Vorhies established his practice in the community in 1938, following in the footsteps of his father and grandfather who were Cambridge physicians. He is a Fellow of the American Academy of Family Physicians.

CARL WASMUTH, M.D., retired in September as Chairman of the Cleveland Clinic Board of Governors after heading the Clinic for the last seven years. Dr. Wasmuth, a lawyer as well as a physician, has been President of the American Society of Anesthesiologists and a member of a national panel on malpractice named to advise the Secretary of Health, Education, and Welfare.

HOWARD B. WEAVER, M.D., Akron, has been elected to the Board of Trustees of Malone College. Dr. Weaver, who is on the staff of Timken Mercy Hospital, is also President of the Stark County Medical Society and the Canton Academy of Medicine. He will serve a three-year term.

ROBERT WHETSTONE, M.D., Pleasantville, has been appointed to the Fairfield County Mental Health and Mental Retardation Board. Dr. Whetstone, who is on the staffs of both Lancaster-Fairfield and Mt. Carmel Hospitals, has practiced in Pleasantville for 20 years.

CHARLES G. ZEGIOB, M.D., Maple Heights, has been appointed to the newly created position of Director of Medical Affairs for Marymount Hospital. Dr. Zegib, a past president of the hospital medical staff, has been both assistant director and director of medical education for the hospital as well as assistant director of medical education in internal medicine. Dr. Zegib is an internist who has been on the hospital staff for 26 years.

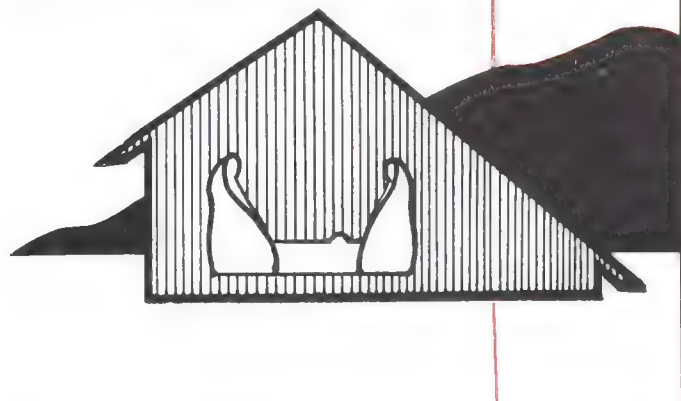
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to earth
a loving grace
that still endures
for all mankind.



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(For Ohio Physicians Only)

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The Medivest, Inc. system, as a matter of policy, will not consider any venture project that cannot provide reasonably justifiable projections that will not show a better than 300-percent return in five years. Medivest, Inc. recognizes that the venture capital situation must offer, as an incentive, an opportunity to substantially increase the available return as compared to the type of relatively low-risk investment opportunity currently attracting the majority of investment capital.

Medivest, Inc. has been organized by persons with extensive executive, administrative, and practical experience in business and financial consulting; who have, during this experience, developed and acquired a confidential list of over 500 sources of projects which meet the Medivest, Inc. criteria, and who are desirous of obtaining capital or guarantees for worthwhile projects. Medivest, Inc. has organized these sources to utilize a computerized data processing system to efficiently match investors, lenders, and guarantors to the financial needs of venture entrepreneurs who have tax sheltered their projects, whereby the requirements of these venture entrepreneurs can be efficiently matched to appropriate investors who have previously indicated to Medivest, Inc. their investment interests, criteria, and tax-planning needs.

The Medivest, Inc. process includes identifying the

client's investment needs (rarely confined only to tax shelters), and obtaining his input concerning investment preferences. A projection of the current year's income tax projection is made, including an analysis of the present tax effects of previously purchased tax-shelter investments. Should the client not have a balance sheet, assistance is given for its preparation. Prior years' tax returns are also evaluated, and from this variety of information, a determination is made concerning the combination of investment vehicles that are appropriate to the clients' total needs.

The Medivest, Inc. process matches tax-shelter investments, and recommends particular programs to clients on the basis of their needs, as determined above. The investment selection process is an in-depth one, consisting of (1) reviewing the track record and business reputation of the syndicator/promoter; (2) analyzing the fairness of the investment structure (comparing the investors' benefits to those of the general partners); and (3) reviewing the underlying economic aspects of the investment. This last area of review is generally conducted with the aid of technical experts with many years of practical on-the-job experience in their respective areas of expertise. The input of these consultants is essential if an intelligent investment decision, based on all relevant facts, is to be made.

When the Medivest, Inc. process locates an investment that meets with the client requirements and is deemed to be otherwise appropriate for the client, the recommendations are forwarded by mail to the client in a report which explores the positive and negative aspects to the investment. The client is then left to decide for himself if the investment is acceptable to him.

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When **impotence** due to androgenic deficiency is driving them apart



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Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.



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To assure prompt delivery, when replying to an advertisement over a **Journal** box number, address letters as follows: Box (insert number), c/o **The Ohio State Medical Journal**, 600 South High Street, Columbus, Ohio 43215.

PSYCHIATRIST: Experienced, seeks an association with a group, a private psychiatric hospital, or a community clinic. Would also consider purchase of a practice. Available February-March 1977. Reply Box 778 c/o Ohio State Medical Journal.

EMERGENCY PHYSICIANS: Full-time, career-oriented northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including malpractice insurance. Full department status. Ohio license required. Write: J. J. Cahill, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094. Telephone: 216/946-4546.

OBSTETRICS AND GYNECOLOGY: Faculty positions available in clinical endocrinology, oncology, and ambulatory care (administrative). Academic appointments, rank, and salaries commensurate with education and ability. Forward curriculum vitae and letter of interest to Dr. Mortimer G. Rosen, Director, Obstetrics and Gynecology, Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland, Ohio 44109.

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NEUROLOGIST needed by 40-physician, multispecialty, group practice. Modern, excellently equipped building adjacent to 265-bed, acute-care hospital in southeastern Ohio. Excellent benefits, paid liability insurance, salary negotiable. Contact: Robert E. Daniel, Administrator, 614/446-5187 collect, or write Holzer Medical Center Clinic, P.O. Box 344, Gallipolis, Ohio 45631.

MEDICAL DIRECTOR / ADMINISTRATOR: Long-term facility with skilled nursing, tuberculosis, pediatric, chronic illness, alcoholism detox and rehab divisions. Full-time position available immediately in 199-bed, J.C.A.H.-approved facility. Ohio state license required. Salary negotiable. For further information write to: Kathryn E. Shearer, Molly Stark Hospital, Box 9122, Canton, Ohio 44711 or Phone: 216/875-5531, ext 248.

FAMILY PRACTITIONER / GENERAL PRACTITIONER (Professional and Income Growth Oriented): Two (2) F.P.'s or G.P.'s are currently being sought by an expanding, family-based clinic located in north central Ohio. Community population 65,000. These positions will provide excellent professional benefits including competitive base salary, company care, life, health and malpractice insurance. Both stock option and partnership to be offered at the end of your first year of association. Substantial vacation and professional education allowances complement the positions. For full details reply in confidence to Administrator, Family Doctor Inc., 312 Park Avenue West, Mansfield, Ohio 44906.

STAFF PHYSICIAN: Long-term facility with skill nursing, tuberculosis, pediatric, chronic illness, alcoholism detox and rehab divisions. Full-time position available immediately in 199-bed, J.C.A.H.-approved facility. Ohio state license required. Salary negotiable. For further information write to: Kathryn E. Shearer, Molly Stark Hospital, Box 9122, Canton, Ohio 44711 or Phone: 216/875-5531, ext. 248.

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INTERNAL MEDICINE PRACTICE FOR SALE: Established practice in a small town of 10,000 with 55-bed hospital. No other internist in town. 40 minutes from Toledo. Two well-equipped rooms. EKG Machine. Available December 15, 1976. Contact: K. N. Zafar, M.D., 925 N. Scott, Napoleon, Ohio 43545. Telephone: 419/599-3271 or 419/599-3751.

PHYSICIANS: The Ohio Department of Mental Health and Mental Retardation is seeking physicians to work in various administrative, clinical, and staff capacities in State facilities or community programs. Salaries range up to \$55,000 commensurate with qualifications, education, and job requirements. An Ohio license or eligibility for a license is a requirement. For more information, submit a curriculum vitae to Mrs. Janey Collins, Recruitment Manager, 30 East Broad Street — Room 1155, Columbus, Ohio 43215.

RADIOLOGIST needed by 40-physician, multispecialty, group practice in southeastern Ohio. Paid liability insurance, excellent benefits, salary negotiable. Contact: Robert E. Daniel, Administrator, 614/446-5187, or write Holzer Medical Center Clinic, P.O. Box 344, Gallipolis, Ohio 45631.

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EMERGENCY PHYSICIAN: Columbus, Ohio. Established EM group with extensive continuing education plans needs an additional physician to improve staffing. Prefer physician who will have completed rotating internship by June 1976, with career orientation. Could accept qualified applicant for one year, July '76 - June '77. Busy EM practice in 600-bed, private teaching hospital with University affiliation (Mount Carmel Medical Center) and 250-bed private suburban hospital with 24-hour medical and surgical in-house coverage (Mount Carmel East Hospital). Must have Ohio license. At least 4 weeks vacation. Excellent starting income, meeting expenses, plus malpractice, hospitalization, disability and life insurance. Call Donald T. Evert, M.D., President, Emergency Services, Inc., 5979 E. Livingston Ave., Columbus, Ohio 43227, (614) 864-0566, 8:30 AM - 5:00 PM, Monday through Friday.

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PHYSICIAN'S 4 ROOM OFFICE FOR RENT—New, 4 doctors building—air condition, free parking, near bus stop, reasonable price. 19451 Euclid Avenue, Euclid, Ohio (Cleveland Suburb) can be seen 5-7, except Thursday. Phone (216) 481-3058.

ASSOCIATE WANTED: Cincinnati Professional Corporation seeks associate. Openings available in emergency rooms and medical centers doing family practice and industrial cases. Medical Health Services, Inc., 5002 Ridge Ave., Cincinnati, Ohio 45209. Telephone: 513/631-0200.

PSYCHIATRISTS: Immediate opportunity to develop a new mental health counseling center for a city/county population of 30,000 and to practice privately. Starting salary \$50,000. An excellent opportunity for a young man who wants to put some of his ideas in community psychiatry into practice. Contact A. C. Diller, M.D., President, (419/749-2114), Van Wert County Mental Health Board, Medical Arts Building, Van Wert, Ohio 45891.

PEDIATRICIAN: Solo or associate practice in city of 40,000. Office space, housing, and 250-bed general hospital with privileges available. (See FAMILY PRACTICE POSITION AVAILABLE ad this issue for more detailed information.) Contact: Robert Flint (614/382-8211), MARION GENERAL HOSPITAL, Marion, Ohio 43302.

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